INTRODUCTION

There is a growing body of literature documenting the impact of conflict on gender and health. For example, more men than women are injured or die from violence during wars, whereas for women, the breakdown in social norms as well as the absence of law and order increases the risk factors for sexual and gender-based violence (Percival et al., 2014; Carlson and Mazurana, 2006). What is less well addressed is the opportunities and challenges for rebuilding health systems from a gender equity perspective once peace commences. A World Bank report argues for a greater focus on the ‘tensions, opportunities and relevance’ of addressing gender issues in post-conflict settings (Anderlini, 2011). A recent literature review suggests that health sector reform in post-conflict contexts, as well as in developing countries, has failed to sufficiently identify the distinct health needs and experiences of men and women, analyse the factors that contribute to that difference, and respond accordingly (Percival et al., 2014).

This chapter analyses research conducted by the ReBUILD1 consortium in Northern Uganda to explore the extent to which gender equity has been considered and realized in the post-conflict reconstruction of the health sector.

POST-CONFLICT GULU DISTRICT: SITUATING THE CONTEXT

Northern Uganda2 has been through cycles of violence, some shorter-term and others longer-term. These conflicts have differed in intensity and scope; sometimes covering the whole of Northern Uganda and sometimes covering only the Acholi (see Figure 20.1) and Lango sub-regions (Gersony, 1997; MoFPED, 2002). After 1991, the Lord’s Resistance Army (LRA) became predominant, plunging the region into widespread civil conflict. This culminated in several people being displaced from their homes and moving into internally displaced people’s (IDP) camps (Kindi, 2010; NRC and IDMC, 2010; IDMC, 2013).

At the peak of the conflict, Kitgum district had the highest number of IDPs in the region, followed by Gulu district (Department of Disaster Preparedness and Refugees, cited in Namakula et al., 2011). The signing of the Cessation of Hostilities agreement in Juba in mid-2006 paved the way for relative peace and the eventual return of IDPs to their former homes (Kindi, 2010; UKPCDP, 2013). IDP camps were demolished and reconstruction in Northern Uganda began. With regard to health, humanitarian agencies that had provided health care services during the conflict left en masse, leaving the
government to fill the void. From the government’s perspective there was a need for the north to catch up with the progress being experienced in other parts of the country.

In response the Government of Uganda (GoU) adopted the Peace, Recovery and Development Plan (PRDP) for Northern Uganda, which became the blueprint for post-conflict reconstruction, spelling out how accelerating progress in Northern Uganda would be achieved. The overall goal of the PRDP is ‘To consolidate peace and lay a foundation for recovery and development in Northern Uganda’ (GoU, 2007: vii). With respect to health services provision, the strategic objective of the PRDP is to reduce morbidity
and mortality from major causes of ill-health and decrease disparity therein, through a strategy of constructing more health facilities to increase the percentage of the population living within 5 kilometers to the nearest health facility, improved service delivery and public health education (GoU, 2007).

The PRDP’s acknowledgement that health indicators in the north are worse than for the rest of the country has seen health facilities reconstructed (UKPCDP, 2013). However, with respect to health services access and use, the north is expected to follow the national guidelines. Hence, the health focus and indicators remain the same as the national ones.

With the end of the war many new health providers were attracted to Northern Uganda, creating a flourishing health care market, and a complex interplay of government and non-government (private) providers. Private providers include drug shops and pharmacies, clinics, faith-based private not-for-profit hospitals and private hospitals. There are also specialized providers, such as The AIDS Support Organization (TASO) for HIV-specialized care. The emergent health care market requires money to access it. All facilities charge fees, ranging from the nominal to exorbitant fees depending on the ailment. This is a sharp contrast to the conflict period when humanitarian agencies provided free health care services to people in IDP camps.

METHODS

We have synthesized and reanalyzed different data collected as part of the ReBUILD project on health systems, human resources and health financing in Northern Uganda in order to analyze the extent to which gender has been understood, addressed and mainstreamed in the post-conflict health system reconstruction. This analysis has included synthesizing and integrating data sets deploying different methods – quantitative (a household survey) and qualitative (including life histories and key informant interviews) – and with different participant groups (women and men at community level, health workers and key informants). The life history analysis discussed here focuses specially on the post-conflict period. The range of complementary methods and data sets included are briefly discussed in turn. Given the critique of traditional scientific research methods in capturing gendered experiences (Mies, 1999), the choice of these methods was made with the aim of giving voice and documenting narratives of women’s lived experiences in the war and its aftermath. Respondents are anonymized by use of either acronyms (for life history participants) and general titles (for key informants). The Appendix lists the acronyms used.

A Mini Household Survey to Analyze Poverty Levels and Household Make-Up

With regard to the quantitative methods, a mini survey was undertaken to determine the poorest households which were then selected to participate in life history interviews. The mini household survey covered 410 households from four villages in four sub-counties of Gulu district. Of these, Layibi and Bardege sub-counties represented urban Gulu while Paicho and Unyama sub-counties represented the rural population of Gulu district. From these, four villages were selected: Wii Layibi from Layibi, Keyi from Bardege, Omel
from Paicho, and Agung from Unyama. While the target was to collect 100 respondents per village, the final sample size was 410 and the selection from each village is presented in Table 20.1. Data from this survey were analyzed using STATA 12 Statistical Software and different poverty proxy indicators were derived, which were used to determine the poorest of the poor in the study area.

### Qualitative Life History Interviews with Households at Community Level

From the mini household survey, 47 households that fulfilled the criteria of being the poorest households were identified for life history interviewing. Life history interviewing refers to a method of qualitative data collection which documents an individual’s life over a time period. Historical analysis is important to illustrate the continuities and changes of any phenomenon under study. In this light, personal histories of household heads (adults aged 45 years and above) were collected to document changes in their households’ ability to cope with household health care costs over the three time periods (pre-, during and post-conflict). Hence the unit of analysis was the household, which in our study referred to residential unit(s) whose occupants commonly shared meals and related productive activities, and decision-making. The household head referred to the socially accepted leader of the residential unit(s). Our study consisted of 26 female and 21 male household heads.

The results of these life history in-depth interviews were analyzed using Atlas ti software. The codes from this phase were entered into Excel and Pivot Tables were generated to determine the magnitude of expressed opinions and suggestions. The findings are presented both qualitatively (using illustrative quotes to highlight key themes) and quantitatively (using frequencies of mentions to highlight the popularity of experiences, views and claims). While the life history covered the three time periods: before, during and after conflict, this chapter focuses on only data for after the war, to highlight the gendered experiences of the post-conflict reconstruction effort. Specifically it focuses on major health events requiring care, including pregnancies and the illness episodes household members experienced since the end of war.

### Qualitative Life History Interviews with Health Workers

Twenty-six serving health workers in four districts of the Acholi sub-region in Northern Uganda – Gulu, Kitgum, Amuru and Pader – were interviewed using the life history method. The life history focused on key stages of their career path including their motivation to join the health work force, their experiences at initial and subsequent trainings,
job selection, and any specific motivators and challenges experienced. We also inquired about their views of any incentive policies they had encountered during their careers, their personal experience and the role of gender, age and family responsibilities in making decisions during and after the conflict. We also interviewed health workers who had worked for ten or more years in the public or private not-for-profit (PNFP) sectors, from Health Centre II to hospital level. We required health workers with more than ten years’ experience as we wanted to understand how their lives have changed since the war (Namakula and Witter, 2014b). These data were analysed thematically using Atlas ti software.

**Key Informant Interviews with Stakeholders Working at Different Levels**

In addition to the life history interviews, we conducted 25 key informant interviews with stakeholders in human resources for health at national, district and facility level in the study areas, and also carried out a document review of human resources for health policies in Uganda since 1999. The key informants interviewed were from the Gulu district medical team, Gulu district leadership team, St Mary’s Hospital Lacor, the Bangladesh Rural Rehabilitation Committee (BRAC), Child Fund and Northern Uganda (NU) Health. Data from these interviews were also analyzed using Atlas ti Software to assess priorities and strategies in health system reconstruction. These sources were triangulated in the final analysis.

**Ethics**

Ethical approval was granted by Makerere University School of Public Health Higher Degrees Research and Ethics Committee, the Uganda National Council for Science and Technology and the University of Liverpool in 2012. The fieldwork with health workers was undertaken in October 2012, while that with households and key informants was undertaken in April and June 2013.

**THE FINDINGS**

The findings are presented against four key areas which emerged from analysis of the different data sets. Building on analysis from key informant interviews we begin by presenting the health systems reconstruction, and maternal and child health in post-conflict reconstruction in the health sector. Drawing on the household survey and analysis of life histories within households we then present household experience of illness episodes, and treatment-seeking patterns analyzing differences between male and female household heads. Finally we analyze the gendered experiences of health care workers in post-conflict Northern Uganda.

**Health System Development in Post-Conflict Gulu: An Overemphasis on Health Facility Reconstruction**

With regard to health, the post-conflict situation health reconstruction continues to focus on infrastructure development rather than improving direct access to health care. Most
key informants reported prioritizing free and equal access to health care as the key health care policy, but this was often equated with the construction of health facilities. District policy leaders and health care providers listed construction of physical health facilities as the main initiative and priority, as indicated in Table 20.2.

Most key informants had undertaken construction of health facilities as a unique initiative to address health concerns of the post-conflict population:

Reconstructions of health care... we have actually ensured all the parishes have health centers. (KI District Health Team, Gulu)

We ensure that all Health Centers have staff quarters but it is not yet adequate. Health Centre IVs and IIIs do not have enough infrastructure... if they continue giving us money under PRDP and from other stakeholders, we will build staff quarters so that staff can really stay there. (KI District Health Team, Gulu)

Most construction funds come from the PRDP. Within the PRDP there is also PHC [Primary Health Care] development fund. That one comes from the centre [central government] for reconstruction includes development fund for construction. We also have PHC where some few Health Centers have benefitted with building. (KI District Health Team, Gulu)

The focus on reconstruction also underpinned other initiatives in the health sector including partnership with donors:

The government sends the conditional grant which is used for building. But where the government cannot fully come in... we engage the development partners... for example Child Fund is constructing Health Centre IIIs in Unyama sub county, fully with solar panel, maternity ward, and staff quarters. Uding is the only parish in Unyama Sub County without a Health Centre II. So we are looking around for any development partners... who could come and support us because the government is delaying. (KI District Leadership Team, Gulu)

As the previous quote illustrates, even the construction was skewed in favor of providing maternity and delivery services. Importantly a focus on construction was not complemented by other schemes to ensure access of the poorest of the poor (for example widows) to health care. Insurance was lacking in government facilities, and only existed in Lacor Hospital for employees of non-governmental organizations (NGOs):

<table>
<thead>
<tr>
<th>Unique initiatives</th>
<th>Frequency (mentions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction of health facilities</td>
<td>46</td>
</tr>
<tr>
<td>Recruitment and training of health personnel</td>
<td>14</td>
</tr>
<tr>
<td>Free health care</td>
<td>13</td>
</tr>
<tr>
<td>Subsidized health care</td>
<td>13</td>
</tr>
<tr>
<td>Specialized services</td>
<td>12</td>
</tr>
<tr>
<td>Health outreaches</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>139</td>
</tr>
</tbody>
</table>

Source: Primary data compiled from key informant interviews.
If there is insurance then it is just private. Even I, am not insured . . . No there is no scheme for insurance sincerely. But if there is any, then it is private. And it is mostly NGOs who have their staff insured. (KI Gulu District Health Team)

There are also insurance companies, the health maintenance organizations. Their clients also come to the private wing. But you know it ends up being the same, either the people working with banks or NGOs and those insured through the health insurances. (KI Faith Based Facility Manager)

With regard to the poor, there was a time of the village health insurance scheme started by USAID [United States Agency for International Development] but it could not survive, so it collapsed. It worked for about two years but it was not sustainable. So it collapsed. They have tried to revive it with no success. (KI Faith Based Facility Manager)

Focusing on physical infrastructure without dealing with the direct challenges of health care access is problematic. In a context of absence of health insurance, the direct costs of seeking health care are likely to limit households’ access to and use of newly constructed health care facilities. This is especially so where limited available services are skewed in favor of maternal and child health (MCH) and facilities are not stocked with adequate medicines or lack appropriate health care personnel.

**Health System Development in Post-Conflict Gulu: An Overemphasis on MCH**

The post-conflict health interventions in Gulu district were similar to the rest of Uganda. All of the service providers interviewed for this study indicated a focus on MCH as the key priority service provided. In one faith-based facility, mothers and children were the key targets of subsidized health care, a continuation of the Mother Uplifting Child Health (MUCH) programme that existed during the war.

The standard is where we directly target the poor . . . when you focus on the out of pocket, you again target the children and mothers plus the vulnerable. Whatever treatment they get for whatever duration children pay only 1000 Ush for outpatient and 10 000 Ush for admission. Then we have the child clinic for under-fives. Then the pregnant mothers pay just 4000 Ush for antenatal and 10 000 Ush for delivery . . . the caesarian section is 6000 Ush. (KI Faith Based Facility Manager, Gulu)

Even the donor-funded programme which was piloting results based financing (RBF) emphasized MCH indicators, even though it claimed the pilot covered all illnesses:

We just use a standard measure. We pay you per indicator. We have a set of quality indicators relating to maternal and child health because we know this is the back bone. If maternal and child health indicators are poor then it means the health in that area is quite weak. (KI Programme Representative, Gulu)

we can see good outcomes and some good quality. There is a decline in neonatal deaths, maternal mortality or maternal death, because the health facilities are determined to realize the importance of some of the things. This is the only humble opportunity you have to assist mothers clearly and make better decisions. (KI Programme Representative, Gulu)

The focus on MCH was also a dominant theme with government-provided services, even when they attempted to provide free health care for all. It informed the nature of health facilities constructed, services provided and indicators of performance of those indicators as illustrated below:
We have ensured that we have done infrastructure, that all the Health Centre IIs have a maternity and staff quarters, although the Health Ministry policy says no delivery at Health Centre II. But we have discovered that you cannot say Health Centre II should not conduct delivery when majority of the people stay in the parishes. Incidentally our Health Centre IIs at the parish levels are delivering more mothers than Health Centre IIIIs at the sub county. (KI District Health Team, Gulu)

if you look at our indicators we are doing well. Our immunization is above 100, our deliveries at 80 percent yet national is at around 40 percent. OPD [Outpatient Department] attendance, immunization, measles and TB T3 is above 100, meaning we are getting some children from other districts. . . . One, accessibility should be there. Another is to reduce maternal deaths, maternal morbidity, infant and neonatal morbidity and death. (KI District Health Team, Gulu)

The MCH focus was also visible in the services of other agencies that had a health component in their work, although they were not primarily health providers. Two worth mentioning here were BRAC and Child Fund. BRAC, largely a microfinance agency, gave out loans ranging from 250,000 Ush to 1.3 million Ush to the poor so as to improve livelihoods. It operated in a 4 kilometer radius:

we work basically with mothers, mainly expectant mothers and children below five years of age. We identify pregnant mothers who we give antenatal services and advise them on pregnancy care. We also encourage them to give birth from the hospitals, after which we follow up with more advice and family planning. For the children we establish if they have been immunized. And in case there are some sicknesses within their families, we refer them to the hospital. (KI BRAC staff, Gulu)

Child Fund was not any different from BRAC. Child Fund, an international NGO, worked in 58 communities. Its presence in Gulu stretched back to 1993, when it was still called Christian Children’s Fund. Its main target was to work with communities to provide services to children, the most prominent of which was child sponsorship. Two years prior to this study, Child Fund had undertaken a project to provide MCH services to the two districts of Gulu and Kitgum, within the Acholi sub-region. In Gulu, it was working with two Health Centre IIIIs and seven Health Center IIs.

we have two projects supporting health. We have the KOICA [Korea International Cooperation Agency] grant for Pediatric HIV in Kitgum and Agago districts. We also have maternal and child health project being developed for three years and funded by Australia government, operating in two districts, Gulu and Kitgum . . . much of the support we give is in terms of co-ordinations and strengthening outreaches. The outreaches focus on immunization and community awareness. (KI Child Fund Staff, Gulu)

Our analysis shows that attention to MCH has dominated the agenda of actors in health service provision and health system reconstruction and strengthening in Gulu district, regardless of whether such actors were government or non-government. This focus informed the nature of facilities constructed, the services provided and indicators on which performance was measured. MCH is clearly important and this is emphasized through the significance of MCH as a key indicator of the health of the health system. However, clearly women and men of different ages experience a wide range of health issues and challenges that go beyond MCH, as explored next.
Gender, Generation and Poverty Shape Household Health Events and Care-Seeking Pathways Amongst Male- and Female-Headed Households

Who are the poorest of the poor in post-conflict Northern Uganda?
From the mini household survey, gender, age and being widowed were the key proxy determinants of being poor. Female household heads who were older, and widows, were more likely to be poor than their married counterparts and male household heads. Female household heads were more likely to be subsistence farmers, without livestock, unemployed and without a wage, as Table 20.3 shows.

This is further illustrated by the wealth ranks derived in Figure 20.2. As displayed in Figure 20.2, of the five wealth quintiles generated, female household heads predominated in the lowest quintile, while males predominated among the highest wealth categories. This shows that in Northern Uganda, older widows had fewer resources at their disposal, including for seeking health care. Yet they had similar numbers of dependants as their male counterparts, with their household sizes ranging from 4 to 14 household members. In fact household size is one variable that did not differ by gender.

Household health events
A complete list of household health events is presented in Table 20.4. From the table, it is clear that MCH issues were just one of many health events households in the study were faced with. Otherwise, the most reported health events in all households, regardless of the gender of the household head, were stomach problems, seizures, coughs, heart disease and body pains, all of which had no exemptions.

The most reported health events in male-headed households in order of occurrence were seizures, stomach problems and body pains, while in female-headed households they were pregnancy and childbirth, stomach problems, coughs, heart disease and HIV/AIDS. The fact that only female household heads reported pregnancy-related conditions, heart disease and HIV could be attributed to their role of caring for the sick. This implies that

Table 20.3 Economic empowerment by gender

<table>
<thead>
<tr>
<th>Employment:</th>
<th>Female (n = 138)</th>
<th>Male (n = 272)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (95 % CI)</td>
<td>% (95 % CI)</td>
<td></td>
</tr>
<tr>
<td>Farmer/peasant</td>
<td>61.6 [19.5, 91.4]</td>
<td>57 [20.8, 87.0]</td>
<td>0.183</td>
</tr>
<tr>
<td>Civil servant</td>
<td>3.6 [0.6, 18.8]</td>
<td>8.5 [2.6, 24.3]</td>
<td></td>
</tr>
<tr>
<td>Politician</td>
<td>-</td>
<td>1.5 [0.5, 4.3]</td>
<td></td>
</tr>
<tr>
<td>Casual laborer</td>
<td>4.3 [0.6, 24.0]</td>
<td>3.7 [0.9, 14.0]</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>4.3 [1.8, 10.2]</td>
<td>2.9 [0.4, 18.9]</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>11.6 [5.5, 22.7]</td>
<td>18.4 [5.2, 48.0]</td>
<td></td>
</tr>
<tr>
<td>Salaried employment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No wage</td>
<td>80.9 [65.1, 90.6]</td>
<td>64.6 [35.3, 85.9]</td>
<td></td>
</tr>
<tr>
<td>Earn a wage</td>
<td>19.1 [9.4, 34.9]</td>
<td>35.4 [14.1, 64.7]</td>
<td>0.011</td>
</tr>
</tbody>
</table>

Source: Primary data from the mini household survey.
Handbook on gender and health

despite having limited resources, female household heads were still expected to care for family members who were either new mothers or terminally ill. Hence, they were likely to end up resorting to treatment sources with inadequate health care provision.

The detailed illustrated life histories in Figures 20.3, 20.4 and 20.5 enable a more detailed close-up look at household health events and treatment-seeking strategies from different households. From the three lifelines, it is clear that the female-headed

Source: Primary data, life history interviews with household heads.
Health Care Source and Cost

- Did not go to hospital,
- No Fees

 Tested from GRRH
- No Fees

2005

Health Care Source and Cost

Major Life Event

Recurrent Incidents of malaria and fever

2006

 Tested HIV Positive
- Started ART
- Elected Council 3
- Representative
- Disclosed HIV Status to wife

2007

 Received training from NUMAT HIV Counsellor
- Married second wife
- Second wife conceived her first child

2009

Second wife delivers first child
- Child is HIV negative
- First wife diagnosed HIV positive

2010

Second wife dies in road accident
- Re-elected for second term as councillor

2011

First wife selected to be a market oriented farmer

2013

Note: GRRH – Gulu Regional Referral Hospital. NUMAT – Northern Uganda Malaria, AIDS and Tuberculosis Programme. ART – anti-retroviral therapy.

Source: Primary data, life history household interviews.

Figure 20.3 Male household head, 50 years
Source: Primary data, life history household interviews.

Figure 20.4 Female household head, 51 years
Major Life Event

- Husband dies of long illness, after going to several facilities in Tororo and admission in Lacor hospital
- Son gets malaria, taken to Bardege Health Center

2004

Health Care Source and Cost

- Treatment from clinics in Tororo was free
- Paid 20 000 Ush at Mulondo clinic
- Paid 100 000 Ush in Lacor Hospital
- Son's treatment in Bardege free

2007

- Goes to Tol Clinic and son's boss paid. She was not told the amount

2010

- She and son go to Bardege Health Center, no payment made
- Treatment from Gulu Hospital was free
- Treatment from Mola Clinic was 90 000 Ush, it was paid by the patient's father
- Stitching and medicine for daughter in law from Tol clinic cost 30 000 Ush. Her employer paid
- Daily dressing from another clinic at a cost
- Self bought 10 tablets from a drug shop, paid 500 Ush

2011

- Son develops a chest problem, vomits blood
- Treated from Tol Clinic
- Fully settled home
- Daughter in law expecting and falls sick with cough and swelling all over the body
- Taken to Gulu and Mola clinic by her father
- Another daughter in law cut by sharp stone at the quarry where she works
- Taken by her employer to Tol clinic for stitching and dressing
- Self develops body pain due to hard work

2012

- Self bought 10 tablets from a drug shop, paid 500 Ush
- Son got free treatment from Bardege Health Center
- Father of grandchildren paid 11 000 Ush for both children's treatment in Lacor Hospital (5500 Ush for each child)

2013

- Another sons falls in pit latrine, develops chest pain, taken to Bardege Health Center
- Grand daughter gets malaria and diarrrhoea, taken to Lacor Hospital, admitted
- Second grand child falls sick, with diarrhoea and vomiting, also taken to Lacor Hospital

Source: Primary data, life history household interviews.

Figure 20.5 Female household head, 63 years
households had more health events, yet being widows they had fewer resources with which to meet them, given that many lost land when their husbands died. For example, the male household reported less illness episodes than the females, yet he had the opportunity to train as a NUMATT HIV Counselor, which sometimes had financial incentives, an opportunity which the females did not have. Also among the females, the younger female (Figure 20.4) had the opportunity to join the savings and grower’s scheme which the older one (Figure 20.5) did not, confirming the view that gender and age were indicators for poverty.

Health care options

With regard to care seeking, the most preferred facilities were government health centers (22.9 percent), Gulu Regional Referral Hospital (GRRH) (22.4 percent), clinics and drug shops (21.9 percent) and Lacor Hospital (15.6 percent). Government facilities (health centers and GRRH) were the first resort because of their policy of free health care. However, most of this free health care stopped at getting a free consultation and basic medicines such as paracetamol or inadequate doses of medicines, due to the frequent shortages of medicines. Hence, all who started from government health facilities ended up also going to drug shops, private clinics and hospitals, either to buy (supplementary) medicines or to seek more advanced health care services.

Moreover, members of male-headed households were more likely to seek health care from government health centers (27.8 percent) and clinics and drug shops (24.1 percent), where money was required to buy the recommended medicines. Meanwhile those from female-headed households were more likely to seek care from the more distant GRRH (23.0 percent), clinics and drug shops (20.4 percent), government health centers (19.5 percent) and the more expensive Lacor Hospital (18.6 percent). This shows that members of female-headed households sought care from a variety of providers. Moreover, they were more likely to seek care from more far-off regional referral hospitals and the more expensive Lacor Hospital because for many female-household heads, seeking health care for a sick member was not immediate, as they took longer to get the resources. Often, they waited for a ‘Good Samaritan’ or relative to help with finances before seeking care (see Table 20.5), or resorted to casual labor to raise the funds (see below, under ‘Strategies to pay for health care costs’). Hence by the time they decided to get care, the health condition would have worsened, requiring more expensive, specialized health care. Besides, Lacor being a mission facility and among the NU Health-supported health facilities offered fairly subsidized health care compared to the fully private for profit health facilities. Moreover, relatives were more likely to assist with paying the health bills of those from female-headed households than those from male-headed households (see Table 20.5):

She [respondent’s mother] took a lot of time . . . the first time, her children [respondent’s siblings] thought she should be put in the private ward so they paid more than one and half million shillings but when her condition worsened, she was taken back and put in the general ward. (LH, female household head, Layibi, Gulu, 50 years)

When my husband fell ill, he was first taken to Mola clinic then Lacor hospital. I could not afford the treatment but his two daughters raised that money for the bills. (LH, Female Household Head, Omel, Gulu 63 years)

When my niece was down with illness [AIDS], the doctor needed 50 000 Ush. Since we no longer
had animals, having lost them all to war, her brother in law contributed three chickens [which were sold to raise 9000 Ush. (LH, Female Household Head, Keyi B, Gulu, 70 years)]

When my grandchild fell ill [with asthma], I sold eggs to raise the money (20 000 Ush) for treatment. The child’s mother also contributed 10000 Ush. (Female Household Head, Layibi, Gulu, 65 years)

This confirms the earlier assertion that they cared for others despite having limited resources. Interestingly, no female household head ever sought health care from the very expensive private for-profit Gulu Independent Hospital.

**Reasons for the health facility choice**

The most common reasons for seeking care from a particular health facility, in order of prominence, were severity of illness (27.8 percent), perceived quality of care (18.5 percent) and ability to pay (10.6 percent). While the gender of the household head did not affect illness severity, it mattered for other reasons. For example, male household heads mentioned quality of care as a key factor more than their female counterparts (20.4 percent compared to 17.6 percent). Meanwhile, female household heads were more likely to consider ability to pay than their male counterparts (13.7 percent versus 4.1 percent). For female household heads, ability to pay was a great challenge, which caused them to delay seeking care for their sick household members. And by the time they decided to seek care, the sick member would be worse off, requiring even more expensive care than that provided at the local health centers. That is why, at this stage, they did not consider free health care as an option, as was the case with male household heads. Moreover, as mentioned earlier, ‘Good Samaritans’ and relatives came in at this stage to help with the hospital bills.

**Strategies to pay for health care costs**

From Table 20.5, most households did not incur a cost in seeking health care, reported more by female household heads. But where they did, the most prominent strategies for raising money to pay for health care were being helped by relatives, selling produce and

<table>
<thead>
<tr>
<th>Strategies for paying for health care</th>
<th>Female</th>
<th>Male</th>
<th>Grand total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq.</td>
<td>%</td>
<td>Freq.</td>
</tr>
<tr>
<td></td>
<td>(n = 74)</td>
<td></td>
<td>(n = 19)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>18</td>
<td>24.3</td>
<td>3</td>
</tr>
<tr>
<td>Helped by relatives</td>
<td>14</td>
<td>18.9</td>
<td>2</td>
</tr>
<tr>
<td>Sold produce</td>
<td>11</td>
<td>14.9</td>
<td>1</td>
</tr>
<tr>
<td>Sold livestock</td>
<td>3</td>
<td>4.1</td>
<td>5</td>
</tr>
<tr>
<td>Income from casual work</td>
<td>5</td>
<td>6.8</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>8.1</td>
<td>–</td>
</tr>
<tr>
<td>Borrowed money from saving scheme</td>
<td>4</td>
<td>5.4</td>
<td>1</td>
</tr>
<tr>
<td>Used salary</td>
<td>2</td>
<td>2.7</td>
<td>3</td>
</tr>
</tbody>
</table>

*Source:* Primary data, life history interviews with household heads.
s selling animals. Of these, male household heads dominated among those who reported selling livestock, given the gendered norms in owning livestock. Female household heads dominated among those who reported being helped by relatives, selling produce and engaging in casual labor before seeking care, all of which had potential negative consequences, given the time it took to wait for a relative to help out, raise money from the sales, and the fact that it was household foodstuffs being sold, exacerbating food insecurity and compounding poverty.

Meanwhile, male household heads dominated among those who used their salary or borrowed money from their relatives. This scenario shows that when confronted with an illness, gender determined how and when household heads engaged the health care system, indicating that female household heads did not have easy access to money.

**GENDER SHAPES HEALTH WORKERS’ EXPERIENCES, EXPECTATIONS AND STRATEGIES TO DEAL WITH CONFLICT**

This was also reflected in our health worker sample of 26 people, which was 77 percent female and focused on mid-level cadres. This was not a sampling choice but reflected the staffing situation in the conflict-affected districts, where those who had stayed during the war and continued to provide front-line health care post-conflict were predominantly female. By cadre, they were clinical officers (16 percent), nurses (58 percent), nursing assistants (8 percent), midwives (12 percent) and others (8 percent). No doctors were found in the facilities to be interviewed. It might have been expected that during a conflict, the gender balance of the workforce might change, with fewer women prepared to expose themselves to the dangers of rebel forces, but this was not the situation on the ground. Data from the human resources for health information system for Uganda indicate that 57 percent of employees are female and 43 percent male. However, at senior management level, female representation drops to 23 percent (MoH, 2012). A research project sampling in eight districts of Uganda found that men occupied 77 percent of senior management jobs in health, while 63 percent of middle management jobs were occupied by men (Newman, 2013; Newman et al., 2014).

Key informants in the human resources study expressed concern about the unbalanced gender composition of health staff in Northern Uganda (Namakula and Witter, 2014b). In the context of understaffed facilities, there is limited ability to cover for maternity leave, which means that roles which are occupied by women are seen as vulnerable:

but midwives are few . . . because in practice, all health centre IIIs and IVs should have a midwife. However, you find that we have only one midwife in each of those levels and if she is on [maternity] leave, there is a big gap because there will be no one to remain. And then the HCHs, with the new construction system, they have a maternity attached but you find that there is no midwife in those facilities. Those are the only challenging part on human resources (KI, District Health Team, Gulu)

**Motivation to Join the Health Profession**

One of the themes addressed in the interviews was the motivation to join the profession. The research highlighted the desire for professional status, particularly the wish to wear
a uniform, attracting staff to join the medical profession for both sexes. Other factors contributing to their decision included their innate caring personality, influences from role models within the participants’ social network, their previous encounters with health workers and the need to ‘pay something back’ to society. Feasibility was also an issue, with the ability to enter training courses which were free, and proximity to hospitals and convents, being cited as decision-making factors. These played out across both sexes. Financial incentives appeared not to be significant at the point of entering the profession. Having an ‘innate caring personality’ was perceived as more common for females:

it was a calling and feeling of wanting to serve people, so I thought that if I am trained I can also come and save the life of my people. (LH male HE, PNFP HF, Kitgum)

I picked interest [of joining medical profession] because right from my childhood, I had that love for caring for the mothers, especially pregnant mothers. (LH Female SNO, PNFP HF, Kitgum)

since childhood, I had so much sympathy for sick people and I could care for any one even before I was trained . . . I have had that heart since I was born. (LH Female EN Public HF, Gulu)

Access to Further Training

As training often required time away from home it was difficult for health workers, particularly women, to attend. The effects of the conflict, plus a duty to care for family members, made it hard for all health workers, especially those working remotely, to upgrade their skills:

I got distinction in all my papers, but 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)

Just to upgrade – you know. So the liberation war interrupted because at that time I had done the interviews and was supposed to come to school and 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)

Juggling family life with training was challenging, and especially so for female household heads and for longer trainings:

During registration life was a bit difficult in the sense that of course you have left a family behind, you left young kids behind so I could think about that kid and I had other children. In 2003 I did a diploma in Community Health that was in Nairobi for 1 year . . . I thought of the children 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)

Career Expectations and Experiences

As health workers progressed in their career, their expectations changed. Staff were more likely to notice and respond to differences in pay and restrictions on earnings across institutions and sectors. There were similar coping mechanisms in relation to low salaries
for both female and male health workers. Respondents coped by carefully managing their resources; some went into agriculture or opened up side enterprises such as drug shops, secretarial bureaus and kiosks, whereas others had to endure family separation to work in different jobs. However females, particularly those who were married, had an extra advantage over their male counterparts and the widows because they commonly got assistance from their husbands:

Yeah during that time (2006) . . . for me I worked for six months without payment . . . but my husband was assisting me . . . During that time he was in Sudan he was 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)

There were also differences across the sexes in professional experiences, which related to the need for women to combine reproductive roles with health work in difficult contexts during the conflict.

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)

Coping with Conflict

The research highlights conflict as a major contextual factor which affected both the lives and career choices of health workers. Participants recalled traumatic situations and innovative coping strategies during conflict, as well as stressing their commitment and resilience throughout this period. Strategies for coping with the conflict included task-shifting (taking on tasks which should have been done by higher-level staff, who were absent), disguising themselves, hiding amongst the community and finding innovative ways to work with limited supplies. They also deployed psychological strategies such as fatalism and relying on their faith (Namakula and Witter, 2014b). Again, different responses by men and women might have been expected but analysis of interviews did not find differences across the sexes. Those who stayed, male and female, were able to find internal and external resources to help them to cope with extreme risks of death and abduction, as well as more mundane challenges of poor working conditions.

Reasons for Change of Jobs

During their active workforce stage, health workers changed jobs and migrated from one place to another. On average, participants changed jobs at least four times during their career. The reasons given for change of jobs included compulsory transfers, transfer on request, insecurity, new posts created through district-splitting, attractions in public and private sectors, and being retained in another region. Although both female and male health workers requested for a transfer in order to go back and be with their families (who were in other districts or in a rural part of the district in which they were working), request for transfer to join family was more common among females in order to be closer to their families, or carry out further productive and reproductive work:
I requested to be transferred from St Joseph’s Kitgum to Kalongo because I was uncomfortable. I had separated from my husband and family. (LH Female, PNFP, Pader)

I was transferred on request to join my family in Gulu. (LH Female PNFP, Kitgum)

I requested to be transferred from Kitgum hospital to Namokora because it is near home. I will also be able to manage my garden and livestock. (LH Male, Public, Kitgum)

Gender Awareness in Human Resources for Health (HRH) Policies

Analysis of all main policies for human resources for health in the past 15 years in Uganda revealed a marked absence of gender analysis. Problems of recruitment, retention, distribution and performance receive considerable attention, with particular focus on hard-to-staff areas and also particular cadres who are in shortage, but there is limited evidence of gender analysis or understanding that gender may play a role or need to be taken into account (Namakula and Witter, 2014a; Newman et al., 2014).

BUILDING A GENDER-FOCUSED HEALTH CARE SYSTEM: WHAT ARE THE LESSONS FROM NORTHERN UGANDA?

With the current discussion on the Sustainable Development Goals there is increasing interest in the social determinants of health and the ways in which gender and other axes of social inequity can influence vulnerability to ill-health, ability to access care and the experience of being a health worker. Post-conflict contexts bring additional challenges here, and there is surprisingly little analysis or guidance available to policy-makers about what constitutes a gender-sensitive health system within or beyond post-conflict contexts (Percival et al., 2014). Our analysis outlines two key and interrelated areas for concern. Firstly, with respect to health service provision, post-conflict reconstruction of the health sector needs to go beyond rebuilding health facilities and a limited focus on maternal and child health, to ensure mechanisms and structures are in place to ensure access to health care for those most in need. This is particularly critical in post-conflict contexts, with impoverished communities and an increase in health providers with a range of charging mechanisms. Secondly, health workers experiences and expectations are mediated by gender, and experiences of conflict are also gendered and need consideration to support health care workers and enable them to deliver in their vital roles. These two areas are discussed in turn.

Health System Reconstruction Needs to go Beyond a Focus on Building Health Facilities and MCH and Respond to the Gendered Health Care Needs and Experiences of Citizens

Historically, post-conflict development has emphasized the reconstruction and rehabilitation of physical infrastructure, justified by massive destruction during war and the need for facilities from which to deliver services. With regard to health this has often resulted in restoring and reconstructing essential services being one of the first responses after conflict (Brinkerhoff, 2008). Our analysis shows that a focus on the construction and rehabilitation of health centers and staff accommodation (Government of Uganda, 2007; UKPDCP, 2013) has indeed been key. Reconstruction of health services is clearly
important; but it cannot be assumed that this will automatically improve access and utilization of the service and needs to be analysed within a context of dependency and limited ability to pay. Health facility reconstruction needs to be accompanied by a recognition that men and women have different treatment-seeking pathways and this is mediated by livelihoods, poverty and access to finances. Strategies to support access of vulnerable groups to health services is vital, and is discussed further below.

In terms of health focus areas, our analysis highlights a strong focus on maternal and child health. This is not unusual in conflict and post-conflict contexts, and often maternal mortality rates are a key (and sometimes the only) indicator of health systems functioning, and can be seen as an indicator of gender equity. While a good measure in ascertaining the state of a country’s health care system, a focus on maternal and child health does not respond to all community health care needs and priorities, and is limited. There is a need to address the gender-related concerns of women who are not pregnant, and men; to analyse the gender differences in other illnesses which are not of a reproductive health nature, communicable or non-communicable, and the gender-related concerns of the health care system. Therefore building a health care system around maternal mortality alone is likely to alienate women who are no longer giving birth, as well as ignoring the provision of health care services in general which women and men need. Consequently, instead of mainstreaming gender in health care provision, this strategy is likely to make matters worse, by ghettoizing women’s health care needs while leaving the rest of the health care system to proceed without paying due attention to gender concerns in health services provision.

Gender differences in health and health care are even more pronounced in conflict, and hence post-conflict reconstruction needs to respond appropriately. For example while women (like men) also face the risk of death, conscription and torture, they also face the challenge of gender-based violence and its multiple repercussions (Annan and Brier, 2009). In the immediate post-conflict period there was action and advocacy in Northern Uganda to support survivors of gender-based violence both within and beyond the health sector, but there have been missed opportunities to link this to overall health systems strengthening.

Building gender-sensitive health systems in the post-conflict trajectory requires both a focus on sexual and reproductive health (including maternal mortality and gender-based violence) and building gender equity considerations into the broader health systems. Stopping at the provision of sexual and reproductive health services is limiting, as women’s and men’s challenges in conflict and consequently post-conflict are broad and varied. Building a gender-sensitive health system requires addressing gender considerations across the board, including all health focus areas such as chronic disease, mental health and tuberculosis, and across all the building blocks in a health system (Percival et al., 2014). Key to this, as our analysis shows, is supporting the access of vulnerable women, men, boys and girls to health services within the fluid post-conflict context.

During conflict the health care system was largely reliant on humanitarian agencies who provided mainly free health services, at least within the context of the IDP and refugee camps. With the coming of peace, humanitarian actors left en masse and were through time replaced by a complex array of health providers, with different payment mechanisms. Our analysis shows how within Gulu poverty is gendered, and elderly women face particular challenges to access health care. More gender-equitable health
financing mechanisms are critically important in post-conflict contexts (Percival et al., 2014). There is a need to address household livelihoods, to ensure that females, as well as male household heads, have the resources to engage with the health care market and its multiple actors. Raising livelihoods is one of the strategic objectives of the PRDP and engendering livelihoods is a key goal of Uganda’s Poverty Eradication Action Plan (PEAP) 2004/5–2007/8. There is a clear need to harmonize post-conflict reconstruction and national sector-wide goals in the PEAP. Short of this, the direct and indirect costs of seeking health care will continue to pose a challenge to health care, especially to those from female-headed households with no resources to promptly seek care. Gender equity in health requires free care, or exemptions for payment or insurance schemes which protect and promote health of vulnerable groups. Ultimately this also means partnership beyond the health sector to support livelihoods, employment rights and access to land.

**Health Workers are Gendered Beings, and There Is a Need to Recognize This and Ensure All Health Workers are Supported to Reach Their Potential in Post-Conflict Contexts**

Our findings from Northern Uganda reinforce recent analysis and discussion of the health workforce as highly gendered (Newman, 2014; Newman et al., 2014). Men typically cluster in more highly paid medical roles and women in less prestigious but crucial mid- and low-level caring, nursing and support roles. In some Organisation for Economic Co-operation and Development (OECD) countries, according to the World Health Organization (WHO), women represent more than 90 percent of nursing and midwifery personnel (WHO, 2008). Within Northern Uganda our analysis confirms gender segregation by roles, and also understaffing in remote areas, and lack of responsiveness to life-course events for workers with family responsibilities play a role in limiting access to training and promotion for women in particular. This was also found in other small-scale studies in Zambia and Uganda (Newman, 2014). Gender-responsive policies and practices are needed to address these issues.

Our in-depth interviews with health workers in conflict-affected areas suggested that the workforce which lived through conflict and continued to work is very female-dominated. This is compatible with the wider health sector statistics, but remains surprising, given the insecurity in the region. Women showed special resilience and courage in staying in areas where physical threats were an everyday risk and reality. In general, the findings suggest the importance of selecting and favoring those with a higher level of intrinsic motivation. This is especially pronounced in difficult times, when pay is erratic, working conditions are difficult, and formal structures of promotion and recognition do not function well. During the conflict in Northern Uganda, health workers displayed values such as empathy, professionalism and selflessness. This is something to be celebrated, rewarded and reinforced after the conflict through, for example, formal recognition of their contribution, increased access to further training and promotion which recognizes and rewards the de facto higher responsibilities which were carried out during the conflict.

The HRH findings of this study also reinforce the wider finding that human resource (HR) policies and planning tend to be gender-blind (Standing, 2000). Given that Uganda has been a leader amongst low- and middle-income countries in promoting gender equality in public life, it is disappointing that nationwide (including Northern Uganda) human resources policies, practices and data do not incorporate a gender lens. The key issues of
focus for HR policies in recent years have been the improvement of working conditions, improvement of recruitment and distribution of health workers, and addressing the training needs of staff. All of these could be more effective if the specific needs of the men and women at all levels in the workforce were taken into consideration. The development of human resource strategies must address gender disparities in advancement, planning, retention, supervision and remuneration across all areas of the health workforce (Percival et al., 2014). Our analysis highlights that this is arguably particularly critical in post-conflict, and fragile and conflict-affected contexts where health workers have faced extremely challenging situations, which require additional support and recognition. This embedded experience of providing health care during conflict brings insights and experience which are critical in post-conflict reconstruction. More strategies to support active involvement of the female and male staff of different cadres in the policy process and in assessing the impact of policies is required. This would produce a more effective and equitable people-centered health system.

CONCLUSION

We have used multiple methods and data sources to analyze health reconstruction efforts in Northern Uganda. Our analysis highlights a number of oversights or missed opportunities in mainstreaming gender equity, and in turn building a robust, resilient and people-centered health system. In summary the focus on physical reconstruction of health facilities needs to be matched with implementation of gender-equitable financing mechanisms to ensure those most in need are not excluded from accessing vital services. A focus on maternal and child health is important but limiting; health systems emerging from conflict need to deliver a basic package of health services that respond to the priorities and needs of all citizens. Ugandan – mainly women – health workers were brave and resourceful in ensuring delivery of care during conflict, and their efforts need to be recognized and their experiences valued. Gender shapes health work experiences during and post-conflict; ensuring responsive mechanisms that enable the voices and perspectives of health workers to feed into health systems strengthening and priorities will produce stronger, more equitable health systems.

There are very few case studies that address or analyse efforts to build gender equity in post-conflict health systems reconstruction efforts. This is an oversight, as the process of post-conflict transition brings opportunities for change. We hope the analyses and recommendations presented here will be acted upon in the ongoing reconstruction of the Northern Uganda health system, and will also offer insights to other fragile and conflict-affected contexts.

NOTES

1. The ReBUILD Consortium is a research partnership funded by the UK Department for International Development. The ReBUILD consortium is working in Cambodia, Sierra Leone, Uganda and Zimbabwe to explore how we can strengthen policy and practice related to health financing and staffing. In health financing we are investigating how different financing strategies affect the poorest households. Our work on human resources studies different management innovations and opportunities for reallocating...
roles among health professionals. Our work on gender is conducted in partnership with the Stockholm International Peace Research Institute (SIPRI)/s gender and ethnicity working group, chaired by Professor Valerie Percival.

2. ‘Northern Uganda’ refers generally to the region stretching from West Nile to Karamoja region and above Lake Kyoga. However, most discussions of Northern Uganda in relation to conflict tend to refer to the Acholi and Lango subregion, with Teso region being referred to as North Eastern Uganda.

3. Drug shops and pharmacies are often the places where most people go for self-medication, which often involves seeking the free opinion (consultation) of the seller.

4. Clinics varied from the general patient outpost to ones which provided outpatient and basic inpatient care. They were often operated by health workers. However, they rarely provided advanced, specialized or inpatient health care.

5. The private not-for-profit faith-based hospitals were mission facilities such as St Mary’s Lacor Hospital in Gulu, St Joseph’s Hospital Kitgum in Kitgum, and St Ambrossoli Hospital Kalongo in Agago District. These provided primary and most of the advanced, specialized and inpatient health care.

6. One private hospital, Gulu Independent Hospital, was established to provide outpatient and inpatient care, primary and specialized health care.

7. Uganda’s health care facilities are organized according to the levels of administrative units under the decentralized system of governance. They are organised as Level I, Level II, Level III, level IV Health Centres, general hospitals and referral hospitals. The distinction is by capacity of patients handled by the facility, procedures the facility can perform, and the catchment area. The higher the level number, the higher the administrative unit, the higher the capacity of patients expected to be served and the greater the range of services to be offered.

REFERENCES


Annan, J. and M. Brier (2009), ‘The Risk of Return: Intimate Partner Violence in Northern Uganda’s Armed Conflict’, Social Science and Medicine, 70, 152–159.


APPENDIX: ACRONYMS

HE – Health Educator
HF – Health Facility
KI – Key Informant
LH – Life History
PNFP – Private Not-For-Profit
SNO – Senior Nursing Officer