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VIEWPOINT

Gender equality needs critical consideration in conflict-affected settings

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The World Bank's 2012 World Development Report calls for gender equality on a global level but falls short on its analysis of conflict-affected contexts. It is critical that we understand the needs of vulnerable populations in these settings. This viewpoint draws on findings from research in health reform in conflict-affected contexts to highlight some opportunities and challenges for addressing gender equality in these settings, using the policy priorities outlined in the World Bank report. Drawing on this analysis we argue that more attention and action should be focused on addressing gender inequalities and inequities in neglected conflict-affected states.

Le Rapport sur le développement dans le monde 2012 de la Banque mondiale lance un appel à l'égalité entre les sexes à l'échelle mondiale mais ne va pas assez loin dans son analyse des contextes touchés par des conflits. Il est crucial que nous comprenions les besoins des populations vulnérables dans ces contextes. Ce point de vue se base sur des conclusions de recherches sur les réformes du système de santé dans les contextes touchés par des conflits afin de mettre en relief quelques opportunités et défis pour assurer l'égalité entre les sexes dans ces contextes, en se servant des priorités de politique générale présentées dans le rapport de la Banque mondiale. Nous nous basons sur cette analyse pour soutenir qu'une attention accrue et des actions plus nombreuses devraient porter sur la lutte contre l'inégalité et l'iniquité entre les sexes dans les États touchés par des conflits qui ont été oubliés.

El Informe sobre el Desarrollo Mundial publicado en 2012 por el Banco Mundial aboga por la igualdad de género en todo el mundo No obstante, su análisis sobre los contextos afectados por conflictos presenta deficiencias si se considera que resulta esencial la comprensión de las necesidades sentidas por las poblaciones vulnerables en tales escenarios. Esta afirmación se sustenta en una investigación que estudió las reformas en salud realizadas en áreas de conflicto con el objetivo de detectar algunas oportunidades y los retos existentes para lograr la igualdad de género en estos contextos, tomando en cuenta las políticas públicas señaladas como prioritarias por el informe del Banco Mundial. A partir de este análisis, las autoras sostienen que debe ponerse más atención en los países afectados por conflictos que actualmente se encuentran desatendidos e impulsar en los mismos un mayor número de acciones orientadas a lograr la igualdad y la equidad de género.

Keywords: Conflict and reconstruction; Gender and diversity; Social sector – Health; Governance and public policy

Introduction

We welcome the 2012 World Bank World Development Report on Gender Equality. This 432-page document provides a comprehensive and persuasive discussion on the importance of

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gender equality in development. However, the report falls short in its discussion of addressing gender equality in countries experiencing and/or recovering from conflict. Estimates suggest that by 2015 just under one third of the global population will live in conflict-affected settings (World Bank 2014). However, apart from a half-page box (Box 7.6, "Including women's voice in peace and post-conflict reconstruction processes"), the report neglects an in-depth analysis of gender equality and development in conflict-affected contexts. This oversight is especially noticeable given the availability of two important working papers via the World Bank website which address a number of questions related to gender equality, development, and conflict. The first, a background paper to the World Bank report itself, argues for a greater focus on the "*tensions, opportunities and relevance*" of addressing gender issues in post-conflict settings (Anderlini 2011, 2). The paper also provides an analysis of existing practices and policies to improve women's protection and participation in such contexts, calling for "*the integration of gender analysis more broadly in tackling fragile states and societies*" (ibid.). The second, a policy research working paper, argues that a "*far wider set of gender issues must be considered to better document the human consequences of war and to design effective post-conflict policies*" (Buvinic et al. 2013, 2). The second of these papers has been publicised through a World Bank blog hosted by its Chief Economist (World Bank 2013). Next we draw on findings from the World Bank report to provide a brief analysis of gender equality in health and development in conflict-affected settings (starting with a brief definition of gender-related terms used).

Gender equality refers to the way in which women and men are treated according to their biological sex and the resources and opportunities to which they have access in their everyday lives. Women's rights activists have sought to reduce discrimination that creates imbalances in women's and girls' (as opposed to men's and boys') access to resources, benefits, services, and decision-making power. The concept of gender equity makes a distinction between the need for "sameness" and "fairness" in the distribution of those resources. Women, men, girls, and boys may require equal access to health, for example, but have different health issues that require different resources. Health policies and programmes must take into account men's and women's different realities in terms of women's reproductive roles (for example in legislating for maternity and paternity leave). Gender roles, relations, and norms refer to the social expectations that exist in societies about how men and women should behave. Gender roles, relations, and norms are embedded in education, political, and economic systems and religion in any given context. We will draw on discussions about gender equality and equity and gender roles, relations, and norms throughout this comment.

The 2012 World Bank report highlights four priority areas for addressing gender equality in development:

- "Reducing gender gaps in human capital endowments (addressing excess female mortality and eliminating pockets of gender disadvantage in education where they persist)
- Closing earnings and productivity gaps between women and men
- Shrinking gender differences in voice
- Limiting the reproduction of gender inequality over time, whether it is through endowments, economic opportunities, or agency" (World Bank 2012, 23).

The report also notes that the priorities will apply differently within different country contexts, as will the policies to address the issues. Including a focus on conflict-affected settings would have increased the report's utility for policymakers and practitioners working on increasing gender equality in those complex contexts.

Drawing on recent research we have conducted in the area of gender equality in health systems reform in post-conflict settings, this viewpoint will focus on insights from selected

findings that relate to the four priority areas highlighted in the World Bank report. First, we briefly outline the research we have been engaged in during 2011–13.

The authors have been collaborating as part of the Stockholm International Peace Research Institute (SIPRI) working group on gender (led by Professor Valerie Percival at Carlton University, Canada). Three of the authors also work within the ReBUILD research programme consortium led by the Liverpool School of Tropical Medicine, UK and focused on rebuilding health systems in post-conflict contexts. As collaborators we have been conducting research to explore opportunities and challenges for building gender-responsive health systems in post-conflict or conflict-affected contexts. Our research has included: reviewing the literature on gender and conflict/peace building; analysis of selected Consolidated Appeals (CAPS) within humanitarian settings; examination of relevant health systems literature; and desk studies of gender equality and equity in health system reconstruction of four countries (Timor-Leste, northern Uganda, Mozambique, and Sierra Leone). Below we summarise our research findings to date before illustrating how these could potentially enhance the World Bank report's conclusions. We emphasise the importance of taking into consideration an analysis of conflict-affected contexts for the four priority areas outlined by the World Bank.

Our research suggests that there are critical challenges and potentially significant opportunities for gender-sensitive policy-making in post-conflict contexts (Percival et al. 2013). However, we argue that health system restructuring has been unable to successfully contribute to addressing gender equality for three principal reasons. First, the focus on gender at the international political level, as reflected in the United Nations Security Council Resolution 1325 on Women, Peace and Security (UNSCR 1325),[1] is to encourage the participation of women within peace negotiations and within elected assemblies; however, there is little focus on equitable representation of men and women within senior decision-making positions in various social sectors, such as health, where the impact of gender inequity is most sharply felt. Second, the focus of humanitarian actors on sexual violence and maternal health outcomes, while critical for women's immediate needs, requires connecting to efforts to address the structural causes of gender inequities to maximise effectiveness and sustainability. Moreover, these programmes enable donors and policymakers to "check" the gender box, without planning more robust, comprehensive health systems strategies that fully address gender inequalities and inequities within these societies. Third, health systems research is largely gender blind, without sufficient detail on how the package of health system reform measures impacts on gender roles and norms. Therefore, there is little guidance or evidence base for those engaged in health system reform on how these interventions could exacerbate or alleviate gender inequity (Percival et al. 2013).

Below we offer some examples to illustrate where opportunities and challenges related to health system reconstruction and gender equity are particularly pertinent to the four key priorities in the 2012 World Bank Report on Gender Equality.

Reducing gender gaps in human capital endowments

The first priority for action highlighted by the World Bank report focuses on human capital endowments, referring specifically to the need to reverse imbalances in excess female mortality and gender disadvantage in education. Multilateral agencies and donors often view the post-crisis period as offering new spaces for manoeuvre within which to undertake wide-ranging reforms of public sector institutions. Where gender disadvantage has been entrenched before and during conflict, there may be opportunities once conflict has subsided to set systems in a new direction, where women can make important gains. For health experts, health sector projects in the post-crisis period can improve the quality and accessibility of health care; increase the effectiveness and efficiency of the health system; ensure equity and expand social

protections; and improve population health (Pavignani 2008; Percival 2008; Sondorp and Patel 2004). Donor resources are often readily available, impediments to change such as political disputes or vested interests may be temporarily absent, and the political will often exists to "*build back better*" (Collier 2009). As a result, national governments are often under pressure from multilateral agencies, such as the World Bank and the World Health Organisation, to undertake ambitious and wide-ranging health system reform measures (Percival 2008). Echoing Buvinic et al.'s (2013) recent analysis, our review of the literature suggests that health systems research is largely gender blind, without sufficient detail on how the package of health system reform measures impacts on gender roles and norms (Percival et al. 2013). There are opportunities for those engaged in health system reform to provide more guidance on how these interventions could exacerbate or alleviate gender inequity. For example, the World Health Organisation focuses its health system reform framework on a series of "building blocks" – service delivery, health workforce, information, medicines, financing, and governance – but fails to provide gender-sensitive indicators that could assist countries to monitor their own progress on gender equality aspects of each building block during the rebuilding process. This is a significant missed opportunity.

Furthermore, data from our country case studies suggest that even where health policy-making in post-conflict settings has been developed to address gender equality, these policies have focused predominantly on medicalised approaches to sexual violence and maternal health (Percival et al. 2013). While providing welcome improvements in women's health outcomes, these health issue-specific approaches have lacked the broader focus required to address underlying structural factors that drive gender inequities and influence women's and men's health status and their access to and use of health services.

Closing earnings and productivity gaps between women and men

Our report did not directly explore gender differences in earnings and productivity in conflict-affected contexts. Nevertheless, from the literature we reviewed there are some useful findings to pull out in relation to these gender gaps. Both women and men may experience severe losses in relation to their livelihoods and productivity during times of conflict, for example, by having to leave their farmlands or other sources of income in order to escape violence. However, conflict often exacerbates underlying inequalities. For example, prevailing cultural norms may restrict women's employment opportunities, thus providing them with even fewer options in times of crisis, where men may find alternative options for work. Women's lack of access to cash may in turn impact on their ability to access health services. A significant crosscutting theme that needs further research is in the area of gender and disability. Commentators note that risks related to conflict may be further exacerbated by the marginalisation experienced by disabled people (Ortoleva 2011). Although our research focuses on gender equity in conflict-affected settings, there is an overlapping and urgent need to explore and understand the increased challenges for disabled women and girls, men and boys. In some contexts these groups face increased stigma and neglect due to impairments which may have occurred during conflict (ibid.).

Among other aspects of health system reform, we reviewed evidence on human resources and gender. Little attention has been paid to gender in the process of workforce restructuring (Standing 2000) and health sector reforms have failed to consider gender while developing and implementing recruitment, retention, and career advancement strategies (Standing 2002).

User fees are the most common form of health financing in conflict-affected settings, whether required through formal or informal channels. Expenditure that already discriminates against the most economically vulnerable can easily become "catastrophic" in conflict and post-conflict

settings (Bornemisza et al. 2010). User fees may discriminate against women where they have fewer wage-labour opportunities and may have lost male family members to war (ibid.). Their inability to access health services due to financial and/or movement constraints may impact on their productivity in the long term. As mentioned in the introduction, the ReBUILD consortium (see www.rebuildconsortium.com) is currently working to explore how policy and practice related to health financing and staffing can be strengthened using experiences from four conflict-affected contexts (Sierra Leone, Cambodia, Zimbabwe, and Uganda). These findings will be useful for understanding gendered implications of staffing and financing in relation to productivity and earnings, among other important areas.

Shrinking gender differences in voice

In 2000, the United Nations adopted Security Council Resolution 1325 on Women, Peace and Security. This landmark resolution recognised the impact of armed conflict on women and girls, highlighting the importance of ensuring women's participation in peace and reconstruction processes. In practice, UNSCR 1325 and its four follow-up resolutions, 1820 (2008), 1888 (2009), 1889 (2009), and 1960 (2010), requested member states to identify and punish perpetrators of sexual violence, enhance women's participation in peace processes, ensure female candidates stand for elected office, and increase women's participation in the security sector. While important to the advancement of gender equality in conflict-affected states, UNSCR 1325 largely limits its focus to women's participation in peace negotiations, the security sector, and within elected office at the national level. Our analysis suggests that while these factors are important, member states have struggled to operationalise a broader gender focus in conflict-affected states, thus missing opportunities to develop broader networks to promote gender equity and to increase women's participation in decision-making across different social sectors (Percival et al. 2013).

Only the United States mentions access to broad health services within its action plan to implement UNSCR 1325 through its humanitarian interventions. Our research suggests that the Women, Peace and Security Agenda driven by UNSCR 1325 and its subsequent resolutions has not sufficiently focused on or prioritised supporting broader networks of women in civil society, beyond those working directly in the political realm, nor has it promoted enhanced engagement of women within sectors such as health (Percival et al. 2013).

The short section in the 2012 World Development Report on Gender Equality focused on shrinking gender differences in voice in conflict-affected regions also refers to the need to increase women's representation in post-conflict reconstruction. Box 7.6 ("Including women's voices in peace and post-conflict reconstruction processes") concludes that there is a need to understand more about enhancing women's participation in the post-conflict period. The World Bank report suggests that there are two possible mechanisms for doing this: first, the introduction of quotas for increasing women's political representation; and second, the introduction of "thematic units" to address gender issues and ensure that they receive due recognition.

While this brief reflection from the World Bank report does not provide a critique of UNSCR 1325, their conclusions support our analysis that in order to shrink gender differences in voice through reconstruction processes, there is a need to engage women in social sectors and at all levels of decision-making. Our findings from country case studies offer concrete examples of how this can be achieved in relation to health system reform. In Mozambique, for example, gender-mainstreaming approaches implemented by the Ministry of Health in the post-conflict period included the introduction of *gender focal points*, staff responsible for incorporating a focus on gender equality and responsible for gathering gender-sensitive data at the grassroots

level. These approaches led to opportunities for enhanced participation and gender analysis of data collected at different levels of the health system, and adaptation of the health service response at local level (Tolhurst et al. 2012). In Timor-Leste, international and national humanitarian and civil society organisations formed important alliances in the post-independence period instrumental in introducing new legislation to address domestic violence. These also provided stimulus for the introduction of gender focal points in health and other social sectors which have been instrumental in making gender issues more visible in policy-making and programming.

Our findings indicate that gender equity interventions must also include engagement with men. Advocates for gender equity in countries affected by conflict recognise the need for proactive approaches to working with men (Buvinic et al. 2013). Our findings from northern Uganda suggest that the strong focus by humanitarian organisations on women's health and women's empowerment during post-conflict reconstruction has led to the marginalisation of men's roles and to the perception that "gender" is primarily a "women's issue". This is an important area for more research and action. While gendered hierarchies often discriminate against women, it is critical for gender-equitable interventions to engage with men. Social dimensions of women's and men's identities are multi-layered and involve age, economic status, ethnicity and religion, among other factors. These intersecting aspects of identity render individuals vulnerable for different reasons and in various ways. There is need for gender-sensitive responses to address these differential vulnerabilities among women and men, boys and girls.

Limiting the reproduction of gender inequality over time

Research has demonstrated that conflict has differential impacts on women and men in all sectors (Enloe 2000; Handrahan 2004; Human Security Report Project 2012; Sen, Östlin, and George 2007). Periods of conflict are a window where gender roles and relations are renegotiated or experienced in different ways. Some commentators have discussed the ways in which this can have positive impacts on women's power and status in both the short and long term as they take up new roles normally reserved for men (Chrostowsky and Long 2013; Hyndman and De Alwis 2003). However, as we argue in our report, conflict can also have a wide range of complex and challenging repercussions for women and men's health and well-being (Percival et al. 2013).

There are several ways in which these impacts manifest. During conflict, women forced from their home face poverty and a heightened risk of additional sexual exploitation (Supervie, Halima, and Blower 2010). While men face a higher risk of dying violently, women may face heightened risks of experiencing sexual and gender-based violence (ibid.). This kind of violence can cause trauma to reproductive organs, and can increase the risk of infectious diseases, forced pregnancy, and mental health problems including anxiety, depression, and post-traumatic stress disorder (Human Security Report Project 2012; Mollica et al. 2004; Sen, Östlin, and George 2007). Research has also demonstrated that rates of unsafe abortion and maternal mortality increase during intense phases of conflict (Enloe 2000).

In the longer term, the risk of gender-based violence remains heightened during the post-conflict trajectory, even after hostilities have ended (Human Security Report Project 2012). Poverty, malnutrition, displacement, civil strife, and the destruction of social networks can produce additive levels of stress and impact on women's capacity to recover from conflict (Handrahan 2004). Moreover, a comprehensive range of reproductive health services may not be available in these periods. The gravity of these impacts underscores the need for gender-equitable policy and practice that is tailored to conflict-affected contexts.

Women and men are heterogeneous groups with diverse needs in post-conflict contexts

Progress towards equitable policy-making, especially in relation to health reform, relies on understanding the context within which reforms need to be made. At present there is little transfer of knowledge available from processes that have been undertaken in conflict-affected settings. The 2012 World Development Report would have benefited from a more in-depth focus on conflict-affected and post-conflict settings.

Echoing arguments from Anderlini (2011) and Buvinic et al. (2013), our report provides examples of the importance of exploring opportunities and challenges for gender equity and equality in conflict-affected contexts, from the perspective of health reform (Percival et al. 2013). By mapping a small selection of our findings to four priority areas for policy and intervention highlighted in the 2012 World Development Report, we suggest that the report could have incorporated a much deeper analysis of gender in conflict-affected settings. We have provided some initial examples to demonstrate the opportunities for such analysis in the area of health reform. However, beyond this, there remains a need to develop consensus on the most appropriate indicators to track progress that recognise and address the differing needs of women and men in such settings. In addition, there is a need for more monitoring and evaluation of existing interventions seeking to incorporate gender equity into health reform in conflict and non-conflict settings. The 2012 World Development Report on Gender Equality provides an important resource for exploring gender equality on a global level. However, their analysis does not go far enough to address the needs of some of the most vulnerable populations. More attention and action should be focused on addressing gender inequalities and inequities in neglected conflict-affected settings.

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Note

1. UNSCR 1325 was adopted by the UN Security Council in 2000 in order to recognise the impact of armed conflict on women and girls. The resolution highlights the importance of ensuring women's participation in peace and reconstruction processes.

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