

## Health Systems Strengthening in Post Conflict Reconstruction: Reflection on Uganda

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### Abstract

This article attempted to define health, health care and health systems and further discussed health reconstruction approaches and why it is important, particularly in post war situations and more specifically in the context of the post war health system development and strengthening in Uganda. In a bid to interrogate to what extent women's health and gender perspectives have been integrated in post conflict reconstruction in Uganda, this article further adopted a gender lens to examine the health sector plans in Uganda.

### Introduction

Health is the level of efficiency of a living thing. For human beings it is the general condition of a persons' mind and body, referring to a person being free from illness, injury or pain. The World Health Organization (WHO) defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity [1]. This definition has been plunged with controversy for lacking operational value and the problem created by the use of the word 'complete' [2]. The following paragraph from the WHO definition states that "the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States." [1]. The relationship between health and peace and security is relevant for this research. There is a close relationship between human security and health, such as the impact of violence and conflict on both an individual's well-being and the entire health care system. Violence and conflict also lead to the collapse of health care systems [3]. Therefore, public health provides a common need that governments should address to benefit individuals and communities towards building sustainable peace.

A number of factors influence the health status of individuals, including their background, lifestyle, economic and social conditions, and spirituality; these are referred to as determinants of health. The WHO identifies the following as the main determinants

of health, the social and economic environment, the physical environment, and the person's individual characteristics and behavior's [4]. These factors determine the wellbeing of an individual.

Health care entails the diagnosis, treatment and prevention of disease, illness, injury and other physical and mental impairments in human beings. A wide range of practitioners including midwifery, obstetrics, nurses and psychologists among others provides health care. It also refers to the work done in providing primary care, secondary care and tertiary care, as well as public health.

Health care systems are organizations established to meet the health needs of the population. The forms of health care systems are dependent on health care planning. Some are developed centrally among governments or other coordinating bodies. According to the WHO, a well-functioning health care system requires a robust financing mechanism, a well-trained and adequately paid work force and reliable information on which to base decisions and policies; including well maintained facilities and logistics to deliver quality medicines and technology. Health provision varies globally. Most wealthy nations provide universal health care except for the United States. Health provision remains a challenge due to the cost required and various social, cultural, political and economic conditions [5].

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A 2008 review of health care around the world by WHO found some common contradictions: people with the resources whose needs for health are less, consume the most care, while those with the least resources consume the least [5]. People that lack social protection and payment for care at the point of service pay huge amounts to get care. Over 100 million people annually fall into poverty because they have to pay for health care. Health services for the poor and marginalized groups are often highly fragmented and severely under-resourced, development aid has been found to add to the fragmentation [5]. This description by the WHO indicates that the situation in none conflict settings may not be so different from that of conflict and post conflict settings. What is obvious is that the conditions of health care provision before the war, would determine the nature and type of health reconstruction.

### **Health Reconstruction**

War impacts negatively on the health of individuals and the health system [6]. During conflicts morbidity and mortality rates are usually high due to war related injuries, sexual violence, forced labour displacement leads to shortages in health care services that increases spread of diseases that could lead to death [7]. Following conflicts, three phases are identified in health sector development; the response to health is usually emergency service provision to address the much needed health care for war impact and reduce mortality. With the establishment of governments', the need for rehabilitation and reconstruction of the health sector becomes paramount, this is then followed by the development of the health sector [6,8].

The system of public health is instrumental in creating the necessary environment for peace building and development. The recovery of the public health system requires concerted efforts on behalf of the peacebuilders and the local government in order to ensure that the population is not substantially affected and is able to participate in the rebuilding of the state. Lowered quality of medical assistance leaves out larger than usual portions of the labor force unable to perform their duties, which in turn translate into economic slowdown if the problem persists over time.

Conflicts usually occur in resource poor countries making it difficult for international community to approach post conflict reconstruction, as situations post war are usually dire. Armed conflicts produce direct casualties as well as impact negatively on health through increase military spending at the expense on social services such as health expenditures. Following the huge destruction of infrastructure including health, public health becomes a huge concern. However, the health status of communities is affected by the levels pre conflict. For example, if the health status of a country is low before the conflict, this signals a huge impact and worst status following the conflict.

The next section reviews some of the approaches that have been used to reconstruct health internationally, this is aimed at increasing the understanding of what has worked in post conflict health reconstruction.

### **Health System Development and strengthening in Post Conflict Settings**

Waters et al. provide three inter-related approaches to the rehabilitation of the health sector post war, they include; an initial response to immediate health needs; the restoration or establishment of a package of essential health services; and rehabilitation of the health system [8]. For most of the countries recovering from conflict these three approaches will depend on their context and the pre-existing conditions of the health status and health system before the war. The situation before the conflict cannot be easily divorced from the impact of the war and the subsequent efforts to rehabilitate the health system.

#### ***Initial Response to Immediate Health Needs***

Most of the responses usually occur immediately after the war and focus on the urgent health needs of the population at that time. However, most health reconstruction responses focus on infrastructure development. Carpenter et al. indicated that evidence from gender-disaggregated data on health shows that in fragile and conflict affected situations women's practical health needs are poorly covered [9]. For example, in Mozambique the refugee population was high, and the possibility of disease spread in displaced peoples' camps was very high, this required an immediate action to address the health needs. However, Keane observed that in one of the districts, the focus was on investment in capital infrastructure instead of the development of sustainable health resources [8]. More so, the project did not consider the changes in the health needs of the population, which had shifted due to the return of displaced people to their homes. Keane's analysis of the population did not include a gender perspective, so it is difficult to ascertain if women and men had the same health needs and if there was equality in the provision of services.

#### ***Restoration or Establishment of a Package of Essential Health Services***

The relief phase has been mostly followed by the move to restore systematic delivery of essential health services; usually focused on a package of cost effective interventions. Most of these packages are developed to respond to the areas of health where the indicators are poor and the need to reduce mortality. The priority services implemented in Mozambique for example was the Expanded Program on Immunization (EPI) for children under five years of age, tetanus immunization for pregnant women, Vitamin A supplementation for high risk population, deworming for children and initial health education campaign [10]. In East Timor the focus was on food security, water and sanitation, immunization, obstetric services and disease surveillance. In Afghanistan the basic health service package included: maternal and new-born health, traditional birth attendants, additional emergency obstetric services; child health and immunization, nutritional supplements, training of community health workers and treatment of mental health [11].

#### ***Rehabilitation of the Health System***

This involves actions to restore essential health services and channel resources towards medium and long-term needs in management, financing and health policy formulation and implementation.

For Sierra Leone the initial health sector reconstruction involved two major components; the restoration of essential health services and the development of public and private sector capacities through district team strengthening, support to the health Ministry, and the promotion of civil society participation. Likewise, in East Timor, the UN Transitional Authority (UNTAET) established the Interim Health Authority to design and lead a health sector rehabilitation and development program. The objectives were mainly to restore access to basic services to the entire population, develop health policies and systems and support ongoing health services focused on equality [12].

In some cases, reconstruction of the health system has mainly been through decentralization, this involves the detachment of the Ministry of Health from direct program implementation and handing the day to day operations of health facilities to districts and local levels. While the role of the Ministry of Health is to set policies, strategic management, human resource planning, quality assurance, budgeting and performance monitoring, and develop sustainable and equitable health care financing mechanisms. Good examples are Kosovo and Uganda [13,14].

Another common factor for these two countries is that the health systems before the war were very poor and weak, so in the post conflict phase it was not an issue of restoring the health system to what existed before the war, but it required a reform of the entire health systems. Two major factors determine the extent of rehabilitation – financial, human and physical inputs and policy issues. The key inputs include financing, human resources, physical infrastructure, information systems; essential drugs and the development of public/private sector capacities. With regards to financing, most of the post conflict countries adopted the sector wide approach for aid coordination and to support the role of NGOs, as was the case in Timor-Leste [15].

### **Description of the Uganda Health System**

In Uganda health care is provided by both the public and private sectors. In the public sector there exists multiple stakeholders, including the Ministries of Health, Local Government, Internal Affairs, and Gender, Labour and Social Development which provide services [16].

At national level, the main roles of the Ministry of Health (MoH) include resource mobilization and budgeting, policy formulation and policy dialogues, strategic planning, regulation, advisory services to other Ministries, establishing standards and quality assurance, capacity development and technical support, coordination of health services and training, monitoring and evaluation of the health sector performance [16,17].

Health services are provided based on the Uganda National Minimum Health Care Package (UNMHCP). The Uganda health system consists of the district health system that includes communities, Village health Teams (VHT), health centers HCs I, II, II, and IV, general hospitals, regional Referral Hospitals (RRH) and National Referral Hospitals (NRH). the RRH and NRH are semi-autonomous institutions. District health services are managed by local governments (GoU/MoH, 2010). The district health

system is further divided into Health Sub-Districts (HSDs). Each HSD should have a referral facility either a HC IV or a general hospital [17].

According to the second National Health Policy, the Ministry of Health and other central level departments have the responsibility to supervise the entire health. At the district level the district health offices have the mandate to supervise the district health system in line with the decentralization policy [17]. The responsibility of the Districts is implementation of the National health policy, planning and management of district health services, provision of disease prevention, health promotion, curative and rehabilitation services, with emphasis on the Minimum Health Care Package, vector control, health education, ensuring provision of safe water and environment sanitation and health data collection, management, interpretation, dissemination and utilization.

The Health Sector Strategic Plan 1 (HSSP1) established a structure for Uganda health sector as shown below: this provides understanding of the different structures of health service provision and is relevant to this study. The Uganda health system is made up of health services delivered by private providers, traditional and complementary practitioners, community-based health, and health promotion activities. The health system structure is divided into three, the district, regional and national levels. The district level health system consists of health centres at the sub-county and district levels. The sub-county has four levels of health care delivery, they include health centers (HC) I, II, III and IV.

HCI is the lowest level and is located at the village level and projected to reach at least 1,000 people. Services at this level are provided by Village Health Teams (VHTs). The VHTs are volunteer community health workers, their main function is to connect rural communities to health facilities, they also health education, preventive services and simple curative services. The major role of the VHTs is community mobilization and empowerment for health actions. Each village in Uganda should have VHTs comprising of 9 – 10 people, who are selected by the village. VHTs provide community-based preventive and promotive health services for a population of 1,000 people per village and support health campaigns and disease surveillance [17,18]. Women's participation is promoted through an affirmative action measure that requires one-third of the selected VHTs to be women, this was to ensure women's participation at the community level.

HCH is the level 2 and located the parish, it is projected to reach 5,000 people and provides outpatient health care services. HCH is managed by an enrolled nurse working with a midwife, two nursing assistants and a health assistant. The type of services provided here includes out-patient curative health services, treatment of common diseases, antenatal care, preventive, promotive and outreach care. Infrastructure expected at this level include outpatient, emergency delivery, placenta pits and medical waste pits.

HCHII is the level 3 of the health structure, it is located at the sub-county levels. Projected to reach up to 20,000 people and should have at least 18 staff managed by the Senior Clinical Officer who also manages the outpatient clinic, others include an

enrolled nurse, midwives and nursing assistants. HCIII's offer preventive, promotive, out-patient curative, maternity, in-patient health services, and laboratory services. HC III have more sophisticated equipment and facilities, although this may not be the case for most of them; they also have in patient services.

HCIV is located at the county and is the level IV health system, it is projected to serve 100,000 people. In addition to services offered at health center level IV, other general services are provided including in-service training, consultation, research for community-based health care programmes, emergency operations and blood transfusion services. HCIVs have wards for women, men and children; they also offer admissions. The HC IV are more equipped with a medical officer, clinical officers, nurses, mid wives, nursing assistants, laboratory technicians and assistants, health inspectors, dentist, accounts assistant and support staff. HC IV constitute the first level referral and usually have emergency care; patients in need of more specialized care are sometimes referred to district or regional hospitals.

HCV is the hospital located at the district headquarters and has all the services in HCIV including specialized clinics like mental health, dentistry and consultant physician. In addition to services offered at health center level IV, other general services are provided including in-service training, consultation and research

for community-based health care programmes. projected to serve 500,000 receives cases from all the other health centers.

These are also referred to as Health Sub Districts (HSDs), they are the implementation levels within a district and are involved in planning, in-service training and supervision of lower-level health Centre's within their areas of responsibility . In the public facilities, patients are referred through the system according to their needs.

The regional referral hospital is in the regions and is the level VI of the health system, it is projected to serve 2,000,000 people. In addition to services offered at the general hospital, specialist services are offered, such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services. Receives cases from all the other health centers. A general hospital provides general curative and preventive services, in-service training, consultation, and research to community-based health care programs

At the national level there is the National Referral Hospital (NRH) which is level VII, that serves 24,700,000 people. It is located in the Uganda Capital Kampala. The NRH provide comprehensive specialist services and are also involved in teaching and research.

**Table 1: Structure of the Uganda Health System**

Level		Health Centre	Population (approx..)	Services provided
District	Health Sub-County	I	Village – 1,000	Community based preventive and promotive health services. Village Health Teams (VHTs)
		II	Parish – 5,000	Preventive, promotive and out-patient curative health services, and outreach care.
		III	Sub-County – 20,000	Preventive, promotive, out-patient curative, maternity, in-patient health services, and laboratory services
		IV	County – 100,000	Preventive, promotive, out-patient curative, maternity, in-patient health services, emergency surgery, blood transfusion and laboratory services
		V	General Hospital – 500,000	In addition to services offered at health centre level IV, other general services are provided including in-service training, consultation and research for community-based health care programmes.
Regional		VI	Regional Referral Hospital- 2,000,000	In addition to services offered at the general hospital, specialist services are offered, such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services.
National		VII	National Referral Hospital – 24,700,000	These provide comprehensive specialist services and are also involved in teaching and research.

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## **Women's Health and Gender in Health Reconstruction**

Women's health refers to health issues specific to human female anatomy; these does not only relate to biological structures such as female genitalia, breast and conditions caused by hormones specific in females; but also include menstruation, contraception, maternal health, menopause, and other medical situations in which women face problems not directly related to their biology such as gender differentiated access to medical care. A broader definition was offered by the Fourth World Conference on Women' to involve women's emotional, social, cultural, spiritual and physical wellbeing; and is determined by the social, political, cultural and economic context of women's lives, as well as by biology [19]. Women's health is positioned within a wider body of knowledge, which places importance of gender as a social determinant of health [20].

The importance of women's health cannot be over emphasized, considering the relevance of women's contribution to development; it is only when women are healthy, they can cope with their productive and reproductive roles effectively [21]. This recognition has been reflected in the various global goals that have been put in place including the first International Safe Motherhood Conference in 1987; the International Conference for Population and Development (ICPD) in 1994; the World Conference on Women in 1995, and the ICPD+5 in 1999.

Conflict aggravates women's vulnerability to ill health, discrimination, and gender-based violence [22]. In conflict situations, women often experience higher incidence of poor health outcomes due to their physical and reproductive needs during pregnancy and childbirth, as most maternal deaths in conflict occur during delivery or in the immediate post-partum period due to lack of availability of quality reproductive and maternal care services [23]. In Afghanistan, twenty years of war led to a maternal mortality ratio in 2002 as high as 1,600 per 100,000 live births, and exceptionally high in rural areas; in most cases 87 percent of these were preventable. In Liberia, the maternal mortality ratio of 578 per 100,000 births in 1999 just before the war began rose to 994 per 100,000 in 2005 at the end of the war. In Sierra Leone, the post war ratio was 1,800 [24,25].

Health status is influenced by multifaceted biological, social, and cultural factors that are highly interrelated and differentiated by gender. Various determinants of women's health are biological, socioeconomic, individual behaviour and psychological factors. Women's disadvantaged social position that is often related to the economic value placed on familial roles, helps perpetuate poor health, early and frequent pregnancy, and a continued cycle of poverty. A research carried out by the International Bank for Reconstruction and Development in 2000 found that women in many parts of the world receive medical treatment less often when sick, and then only at a more advanced stage of disease. In addition, in countries where women are less educated and have less control over decision-making and family resources, they are also less apt to recognize health problems or to seek care.

### ***Gender and Health Reconstruction***

Gender is an important signal of inequality and disadvantage in

health care. Gender is an indicator to vulnerability in the sense that women are found among the most vulnerable population groups [26,27]. They tend to be poorer than men, they have less access to income earning opportunities and other resources, including health care, and they depend more on others for their security. Also, women's access to health services are essentially influenced by cultural and ideological factors, such as lack of freedom to act without permission from husbands or senior family members and low valuation of the health needs of women and girls compared to that of men and boys. The provision of health is not gender neutral neither are institutions responsible for health provision gender neutral [26-29].

Post conflict period provides an opportunity for multilateral agencies, donors and governments to undertake wide-range reforms of public sector institutions. In the case of the health sector, undertakings have the potential to improve the quality and accessibility of health care; increase the effectiveness and efficiency of health systems; ensure equity and expand social protection and improve the health of the entire population [26].

### ***Gender Analysis of the Uganda Health Sector Development Plans 2000 – 2015***

The review of the Health Sector Strategic Plan 2000/1 – 2004/5 (HSSPI); Health Sector Strategic Plan 2005/6 – 2009/10 (HSSPII); and the Health Sector Investment Plan 2014/15 – 2014/15 aimed to identify the level of commitment of the government of Uganda to gender equity in health care. An analysis of the three plans mentioned above assessed the various areas where women's needs and gender where given attention, the analysis of these provisions are provided below [30].

### ***Health Sector Strategic Plan 1 2000/2001-2004/2005 (HSSPI)***

The focus of the HSSPI was to deliver the Uganda National Minimum Health Care Package (UNMHCP) through the Sector Wide Approach (SWAp) to enable effective coordination of support to the health system reform. The UNMHCP had twelve technical programmes; one of them was 'sexual and reproductive health and rights' other programmes include; control of communicable diseases, integrated management of childhood illness, immunization, environmental health, health education and promotion, school health, epidemic and disaster prevention, preparedness and response, improving nutrition, interventions against diseases targeted for elimination or eradication, strengthening mental health services and essential clinical care (GoU/MoH, HSSPI 2000:15-16). While it is true that all the areas affect women and men, the differential impact on women and men is not mentioned, which indicates a lack of gender analysis.

Apart from having sexual and reproductive rights as a programme area, other programme areas had targets that focused on women's health, for example one of the target areas for the objectives was to prevent and control malaria morbidity and mortality. Under control of communicable diseases is '60% of the proportion of pregnant women to receive protection against malaria through intermittent presumptive treatment with SP' (GoU/MoH HSSPI 2000:16). Data from the 2009 Uganda Malaria Indicator survey indicates

that malaria parasitaemia was high in most regions of the country, this explains the focus on malaria [31]. However, the policy tends to focus more on women's health without making explicit why the focus on women. Traditional health planning usually focuses on the reproductive role of women for health planning. There is no data to indicate if more women die of malaria; the data that is used is that for maternity care as women will usually register. Focusing more on women without understanding the status of men, have the tendency to lead to more death by men.

On prevention and control of STD/HIV/AIDS one of the targets was to 'increase female condom uses to about 25% for both urban and rural areas' (GoU/MoH, HSSP1, 2000:17). The focus on female condom use ignores that women may not have the capacity to negotiate the use of condom. To be gender sensitive, the policy could have provided for 'increase condom uses for females and males'.

Under the programme for control of communicable disease, the implementation strategy states that: 'gender specific strategies will be developed to ensure that both men and women are involved in the prevention and control of communicable diseases' (GoU/MoH, HSSP1, 2000:17). However, in the logical framework the HSSP1 failed to ensure gender responsive indicators to monitor the proposed targets, this responsibility was left to the district.

Under the integrated management of childhood illness, one of the planned areas of achievement was "improved gender specific community capacity for correct home care seeking behaviour for common childhood illness with special attention on mothers and children" (GoU/MoH HSSP1, 2000:21). The implementation strategy also indicated that "specific strategies will be developed for both women and men involved in management of common childhood illness and diarrhoeal disease" (GoU/MoH, HSSP1, 2000:21). This is one out of the two instances that the HSSP1 referred to women and men in policy, recognizing the role that men play in managing childhood illnesses, specifically that both women and men have the responsibility to provide care for children.

Under the health education and promotion programme, which aimed to "promote individual and community responsibility for better health" (GoU/MoH HSSP1, 2000:33), the implementation strategy gives the district the "responsibility for planning, management, monitoring and co-ordination of gender responsive Information Education and Communication (IEC) activities with all agencies working at the District" (GoU/MoH HSSP1, 2000:33). The acknowledgement of the need for gender sensitive IEC activities means the HSSP1 identified that women and men play different roles within the community and will need different forms of information and education communication for improved health. To ensure this is achieved one of the planned activities was to "develop capacity for gender responsive IEC at all levels" (GoU/MoH HSSP1, 2000:34).

Surprisingly, under the school health programme the HSSP1 identified the provision of toilets but failed to indicate the need for separate toilets for females and males in schools as a means to improve the health status of girls in school. The HSSP1 uses

gender sensitive language but lacks gender analysis. One of the activities at operational level is to "develop a gender sensitive national health policy; and develop and implement a gender sensitive school health programme". Including to "conduct gender advocacy meetings and IEC campaigns" (GoU/MoH HSSP1, 2000:36). The need to conduct gender responsive IEC on emergency, epidemic and disaster response is one of the programmes under epidemic and disaster prevention, preparedness and response (GoU/MoH HSSP1, 2000:37). The use of the word gender/gender responsive/gender sensitive in the policy is noteworthy; the HSSP1 mentioned the word gender five times, gender responsive nineteen times and gender sensitive eight times.

Under the improving nutrition programme, the HSSP1 planned to increase exclusive breast feeding at 6 months from 68% to 75% (GoU/MoH HSSP1, 2000:24), but does not provide plans on how mothers will be enabled to achieve exclusive breastfeeding, apart from mentioning that the programme will "intensify gender responsive advocacy and social mobilization for nutrition at all levels" (GoU/MoH HSSP1, 2000:40). The first operational activity to achieve this target was to "develop policy and formulate gender responsive policy guidelines in collaboration with all key actors" (GoU/MoH HSSP1, 2000:42). So it seems the improved nutrition targeted is for the child and not the mother.

The second objective is to "conduct gender responsive IEC on diseases targeted for elimination and eradication" (GoU/MoH HSSP1, 2000:43). There is also a corresponding activity to "develop/update gender specific guidelines and plans for elimination/eradication of diseases" (GoU/MoH HSSP1, 2000:44). Even though the inclusion of gender in the policy may be well intended the extent to which this was implemented is yet to be explored by research.

The programme on mental health did not make reference to gender responsiveness, however one of the verifiable indicators for the output on 'mental health services expanded and strengthened' is the "number of health workers trained on psychological support on violence against women" (GoU/MoH HSSP1, 2000:46). This will contribute to achieving provisions of the Constitution. There is the assumption that once health workers are trained on violence against women, survivors will have access to them. In post conflict settings, they are few health workers due to hard working conditions and limited social infrastructures.

In the essential clinical care programme, one of the operational activities was to "produce and disseminate gender responsive IEC materials and messages to communities and health workers" (GoU/MoH HSSP1, 2000:49). It also provided for guidelines for periodic examination on communicable disease to take into account sex and age (GoU/MoH HSSP1, 2000). This is good and will lead to increased access to health care services if the right communication tools and materials are developed.

On human resource development, although there was no emphasis on ensuring gender sensitive recruitment and capacity development the verifiable indicators include "proportionate numbers for males and females in health services"; activities also include to

“promote gender sensitive training” (GoU/MoH HSSP1, 2000:62).

Overall, the HSSP1 can be said to have focused on the needs of women, however, the needs are related to the reproductive roles of women. Even though it is clear that reproductive health and rights is one of the programme areas, it was only limited to maternal and child health and family planning, and not any other aspects of health according to the WHO definition.

### ***Sexual and Reproductive Health and Rights (SRHR)***

The objective of the SRHR is “to contribute to reduction of maternal, peri-natal, infant and under-5 morbidity and mortality rates to ensure reduced fertility rate and improved maternal and infant health” (GoU/MoH HSSP1, 2000:24). The targets to achieve the set objectives focus on “reduced maternal mortality ratio by 30%; increased contraceptive prevalence rate; increased deliveries supervised by skilled health workers; and increased Tetanus Toxoid coverage for pregnant women” (GoU/MoH HSSP1, 2000:24). All the indicators focus on maternal health and family planning. First officially recognized at the International Conference on Population and Development (ICPD) sexual and reproductive rights are the rights for everyone to make decision about their sexual and reproductive health, including the choice to marry and determine the number, timing and spacing of their children; to sexual and reproductive security free from coercion and violence; to be informed and have access to safe and legal family planning services and to have access to healthcare services enabling women to go safely through pregnancy and childbirth [32].

According to WHO sexual health is “a state of physical, emotional, mental and social wellbeing, in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” [33]. This definition is broader than that provided for in the HSSP1.

Generally, while the HSSP1 could be said to have indicated the commitment of the Government to ensure gender equity in health service provision, developing and producing gender responsive IEC materials was a major strategy for achieving most of the objectives of the HSSP1, and was mentioned nineteen times in the document, much higher than any other approach to ensure good health for the entire population.

### ***Health Sector Strategic Plan 2 (HSSP2) 2005/2006 – 2009/2010***

Similar to the HSSP1, the goal of the HSSP2 was to reduce mortality and morbidity through the SWAp and the UNMHCP. The elements of the UNMHCP in the HSSP2 were regrouped into 4 clusters to promote increased coordination in planning, budgeting and implementation. These are: Cluster 1 – Health Promotion, Disease Prevention and Community Health Initiatives, Cluster 2 - Maternal and Child Health, Cluster 3 - Control of Communicable Diseases and Cluster 4 - Control of Non- Communicable Diseases/ Conditions.

The principles for the implementation of the HSSP2 recognized the need to focus on different categories of people including the poor, women, children, IDPs and people living in areas of insecurity [34]. The HSSP2 recognized the link between gender and poverty and its relevance to health status and access to health care, it therefore called for the adoption of a gender mainstreaming strategy to address the gender issues in the health sector (GoU/MoH, 2005). The guiding principles for the implementation of the HSSP2 called for the establishment of affirmative action to ensure the attainment of health equity through paying special attention to the most vulnerable groups including women, children, the poor, people living with disabilities and IDPs. It further called for attention to gender concerns in the HSSP2 to take into account the socio-economic differences between women and men that influence their accessibility and utilization of health services (GoU/MoH, 2005). This level of recognition to gender needs and concerns is laudable as it shows that the policy is gender sensitive in addressing the needs of women, men and other categories.

The HSSP2 recognized the Village Health Team (VHT) as the lowest health structure described as Health Centre1 (HC1), whose role is to facilitate the process of community mobilization and empowerment for health action. It also calls for the membership of the VHT to comprise of at least one third of women out of 9 to 10 members to be nominated by the village LCI (GoU/MoH, 2005).

In the core intervention areas of HSSP2, the research identified two key gender responsive areas under cluster 2–maternal and child health and cluster 4–prevention and control of non-communicable diseases, which include sexual and reproductive health and rights and gender based violence respectively. The core interventions for sexual and reproductive health and rights focused on ensuring that emergency obstetric care exist at HC III and IV, community mobilization and capacity building for reproductive health care, antenatal care, SRH as part of integrated sustainable outreach services, provision of family planning including improving access for adolescents, advocacy and IEC on RH services and improved capacity to deliver RH services. The interventions are similar to those carried out in HSSP1 that basically focus on maternal care, family planning and RH. This is understandable as the indicators to improve health also focus on these areas of concern, it ignores that fact that men and unmarried women also have reproductive health needs.

The core intervention areas for gender based violence (GBV) include data collection and analysis to support formulation of strategic interventions for the health sector, campaign to raise awareness about GBV amongst health workers, support to agencies and organizations that work to address GBV and enhance partnership with relevant sectors and civil society organizations (GoU/MoH, 2005).

### ***Health Sector Strategic Investment Plan (HSSIP) 2010/11-2014/15***

The Health Sector Strategic and Investment Plan (2010/11 – 2014/15) was developed to align with the National Development Plan (NDP) 2010/11 – 2014/15. The theme of the NDP was ‘growth, employment and socio-economic transformation for prosperity’ aimed to accelerate transformation of Uganda society

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from a peasant to modern and prosperous country [35].

The investment focus of the HSSIP include human resources for health, health infrastructure, essential medicines, health and other health commodities, health information system, preventive health/health promotion and education, and management and coordination of health sector activities (GoU/MoH HSSIP, 2010).

To ensure all Uganda's attain the highest standard of physical and mental health, the guiding principles of the HSSIP aligns with the Uganda Patients' Charter, the Uganda Constitution (1995) and various international and regional human rights frameworks that Uganda has signed, including the Universal Declaration of Human Rights (1948), the International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), the Convention on the Rights of the Child (1989), the Convention on the rights of Persons with Disabilities (2006), the African Charter on Human and People's Rights (1979), and the African Charter on the Rights and Welfare of the Child (1990) (GoU/MoH, HSSIP 2010). Others include the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008) and the International Health Partnerships and related Initiatives (2008) (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness (HSSIP, 2010).

The principles of the HSSIP are: equality and non-discrimination, participation and accountability and the right to health elements of availability, accessibility, acceptability and quality. These principles are similar to those proposed by Penchansky (1981) who suggested the concept of 'fit' between the patient's needs and the system's ability to meet those needs. The HSSIP therefore used these principles as a means to measure the effectiveness of health care services in Uganda; availability (demand compared to supply), accessibility (location, travel resources), accommodation (organization of care), affordability (income compared to price) and acceptability (attitude and culture of the community). Both accommodation and affordability could form part of the quality of care as proposed by Penchansky and measure appropriateness of services [36].

An analysis of the HSSIP reveals that the critical health determinants affecting the health of Ugandans include sustainable population and high fertility, safe hygiene and sanitation, gender norms, education, and housing and urbanization.

### ***Human Rights Perspective to Health Care***

The guiding principles for HSSIP include gender-sensitive and responsive health care, policy formulation and programming, and calls for a human rights and gender-sensitive and responsive national health delivery system that shall be achieved and strengthened through mainstreaming human rights and gender analysis in planning and implementation of all health programs. To facilitate and strengthen the evidence base for human rights and gender mainstreaming, efforts shall always be made to disaggregate health data by age and sex and gender analysis carried out on the results in order to enhance the effectiveness and efficiency of interventions and programmes (HSSIP, 2010). This perspective indicates

the high level of commitment of government in the area of gender responsive policy development. However, further review of existing health data indicates that most of the data are not disaggregated by gender or other social categories.

The HSSIP have the following objectives to achieve universal coverage of health: Scale up critical interventions for health with emphasis on vulnerable populations, Improve the levels, and equity in access and demand for health, accelerate quality and safety improvements for health and health services, improve efficiency and effectiveness of resource management for service delivery, and deepen stewardship of the health agenda. The objectives of the HSSIP can be said to be gender blind. Kabeer argues that such policies have assumptions that incorporate biases in favour of existing gender relations and so tend to exclude men [37]. It mentions vulnerable groups and there is the assumption that only women and people living with disabilities are vulnerable, but they are also men and boys who are vulnerable particularly in post conflict situations.

The priority areas of intervention for HSSIP had 4 clusters. An analysis of the clusters indicates that the HSSIP had some level of gender analysis and gender disaggregated data only when it relates to maternal health, gender-based violence and nutrition. In many instances reference was made to communities and population, this neutral language makes it difficult to ascertain the level of gender sensitivity and gender responsiveness of a policy.

It is important to note that HSSIP gave specific recognition and attention to people in the PRDP areas, it specifically has an intervention area that seek 'to ensure equitable access by people in PRDP districts (in conflict and post conflict situations) to health services' (GOU HSSIP, 2010). The main focus is 'to strengthen health services through the construction and rehabilitation of health facilities towards improved quality of service. As a result, the only indicator in this intervention area is 'increased access to functional health facilities; to enable a larger percentage of the population to be within 5 kilometers or less of the health facility.' (GoU HSSIP, 2010).

Another area of the policy that was gender sensitive is the cluster on control of communicable diseases which focuses on HIV and Mother to Child Transmission (MTCT). The activities specifically describe the need to distribute female and male condoms, ensure training materials incorporate strong elements of gender responsiveness, male circumcision and ante natal services. For this cluster it was clear that gender was given due consideration. In terms of language the HSSIP is not so different from previous health sector plans, even though the words women, gender, males and men where used, it was only in relation to sexual and reproductive health, gender dimensions seem to elude other areas of health sector plans.

There was only one gender sensitive indicator in the plan under the strategy to strengthen advocacy and social mobilization for behavioural change. It states 'the prevalence of anemia among children decreased from 75% to 60%, women from 49% to 30% and men from 20% to 15%.' This type of indicator enables planning and



budgeting in order to achieve the set target.

**Table 2: Summary of Findings**

Assessment area	HSSP1	HSSP2	HSSIP
Gender analysis	Lack gender analysis	Lack gender analysis	To a limited extent considered gender analysis
Gender disaggregated data	Limited use of gender disaggregated data only related to women and children's health	Limited use of gender disaggregated data only related to women and children's health	Limited use of gender disaggregated data only related to women and children's health
Gender sensitive language	Use of gender sensitive language limited to maternal health. In many cases refer to community and the population.	Use of gender sensitive language limited to maternal health. In many cases refer to community and the population.	Use of gender sensitive language limited to maternal health. In many cases refer to community and the population.
Gender Sensitive indicators	Few indicators consider gender. Goal focus on reduction of mortality and morbidity.	Guiding principle pay attention to vulnerable groups. Few indicators consider gender	Few indicators consider gender

In summary, the health sector strategy plans to a limited extent consider gender but specifically when it has to do with sexual and reproductive health in the areas of maternal and child health, other areas of health lack gender analysis or gender considerations, making it difficult to ascertain the gender dimensions of those areas of health and therefore making health interventions gender blind in those areas.

### Conclusion

In this article, we have been able to define health, health systems and health reconstruction. Health reconstruction approaches in post conflict settings which includes initial response to immediate health needs, the restoration or establishment of a package of essential health services and rehabilitation of the health systems using examples from post conflict countries has been described. More specifically health systems development and strengthening in Uganda from a historical perspective, to get an in dept. understanding of how the health system has developed over the years has been reviewed. What is significant is that while Uganda tended to apply approaches used in other post conflict countries for building health care, the poor development of the health care systems is rooted in the many years of conflict that depleted the postcolonial gains in health development. The legacy of the long period of war remains in the shadow of achieving health equity [38-46].

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