Health systems in conflict affected states - are they different from in other low and middle income countries? Early ideas from the work of the ReBUILD programme.

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Structure

- Introduction: definitions and starting points
- Relevant points emerging from literature reviews on health financing and HRH in post conflict settings
- Preliminary work on gender equity in post conflict health systems
- Case study of Sierra Leone
- Some thoughts for discussion about the distinctiveness of post conflict health system issues

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Fragile states

Lack of ability or willingness to establish preconditions for long-term development
OECD 2005

Cannot or will not deliver core functions to the majority of its people
DFID 2005

Lack of resilience....capacity, institutions, legitimacy, resources and effective processes to support a social compact combine to produce 'resilience'
Eldon et al. 2008

Key points

No universally accepted definition for fragile

Donors have different criteria and lists

Most countries exhibit some of these characteristics (fragility may be the norm...)

These states are temporary but non-linear

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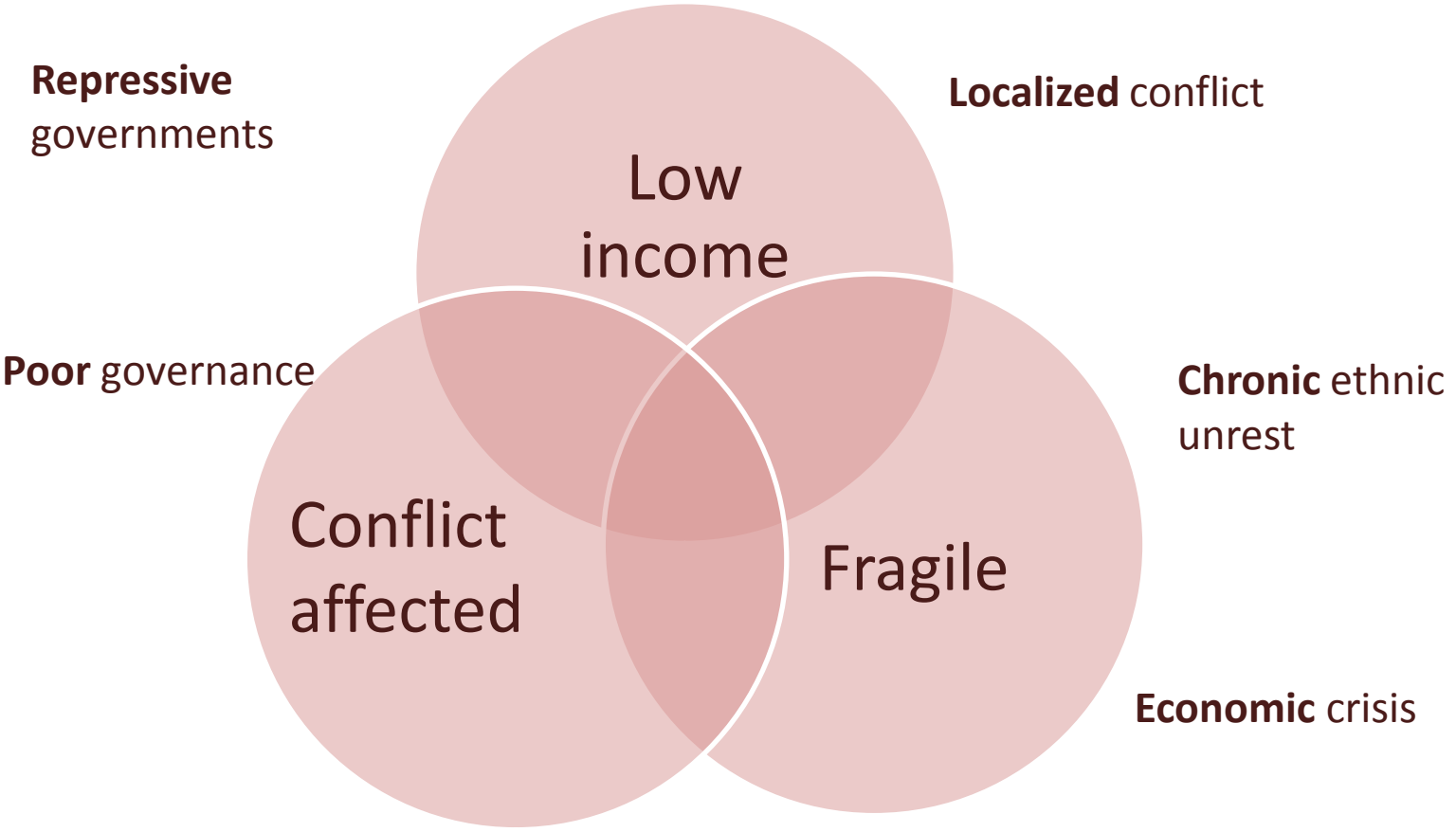
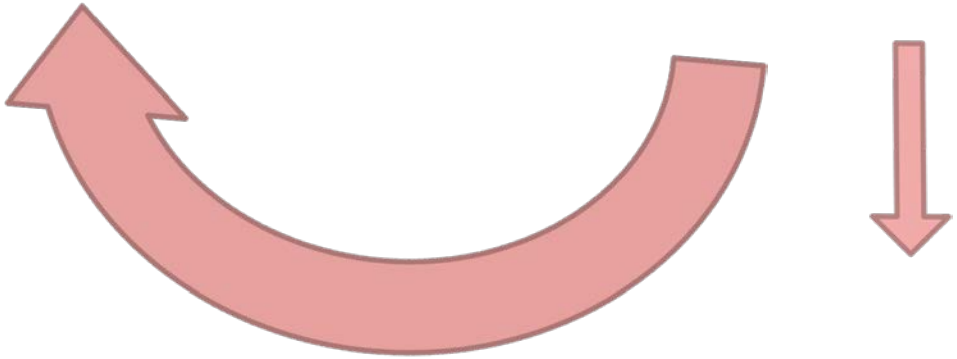
Post conflict



Different aspects of fragility are usually intertwined (Pavignani & Colombo 2009)

Different stages

Deteriorating state → Collapsed state → State recovering from conflict



40% of countries relapse into conflict (Collier and Hoefller, 2004)

Emergency & stabilisation (1 year) → Transition & recovery (1-4 years) → Peace and development (4-10 years)

Source: DAC, 2005; Ahonsi, 2010

Why focus on fragile & post conflict states?

Need

- Fragile states are home to **one-sixth of the world's population**, but one-third of those living on less than US$ 1 per day
- More than **a third of maternal deaths worldwide** occur in a fragile state
- **Half of the children who die before age five** live in a fragile state
- Essential to **achieving MDGs**

Externalities

- Seen also as reservoirs of disease, conflict and terrorism for region

Underinvestment

- However, fragile states receive around 40% less aid than predicted (Dollar and Levin, 2005)

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Different characteristics?

Fragile / post conflict health systems

- Insufficient **coordination, oversight and monitoring** of health services
- Lack of **equity** in who receives the available health services
- Lack of mechanisms for developing, establishing and implementing **national health policies**
- Non-operational health **information systems**
- Inadequate **management capacity**.
- Inability to provide **health services to a large proportion of the population**
- Ineffective or nonexistent **referral systems**
- Lack of **infrastructure** for delivering health services
- Nonexistent or inadequate **capacity-building systems**.

Source: Newbrander et al. 2011

Why might things be different?

Disruption of disease control programmes

Destruction of infrastructure

Interruption of drug supply

Capacity for coordination, regulation and trust

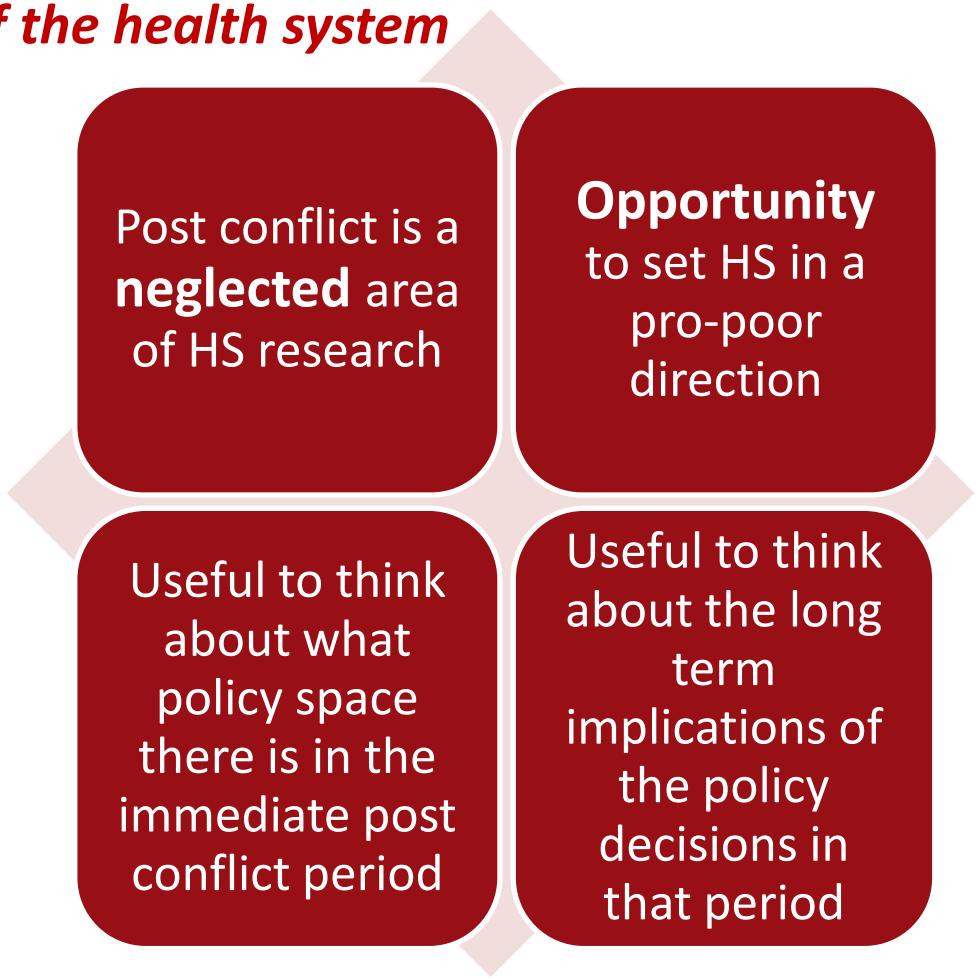
Flight of health professionals

Displacement of communities

Makerere University College of Health Sciences

Key starting points

Decisions made early post-conflict can steer the long term development of the health system



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Review

Health financing in fragile and post-conflict states: What do we know and what are the gaps?

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Critique of existing literature

Timeframes

Neglected topics

Methodological

Health financing and state building

Design can communicate political and social values

Social solidarity	Inclusion and equity	Reconciliation	Human rights	Participation	Confidence in public stewardship

Some writing on this (Kruk et al 2010), but underdeveloped still

Key messages

Discontinuities in health system functioning influence:

Workforce markets

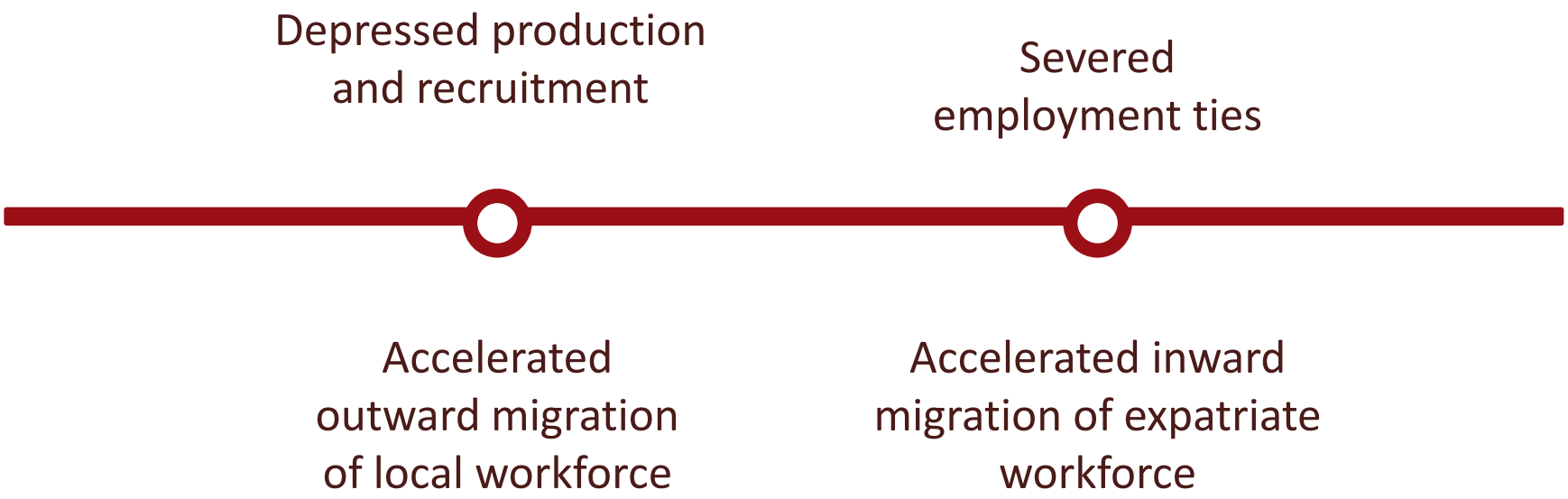
- Production
- Recruitment
- Available stock

Governance of health system actors

- Rapid transformation from public to multi-actor system
- State capacity to direct a more pluralistic health system

Labour market dynamics during conflict

Conflict upsets health labour markets:



Source: Martineau et al. (2012) Human resources for health in post conflict settings situation analysis, ReBuild Consortium

Occupational hazards for workforce

Workforce vulnerability in conflict areas

Health Workers are prized resources for conflicting parties	Health facilities become targets for looting	Workload escalation due to heightened health care needs	Failing health support systems

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Health worker attraction, retention and distribution are critical factors affecting workforce performance

In post-conflict settings, health systems and health worker livelihoods have been disrupted

Temporary service delivery arrangements during conflict, often provided by NGOs may provide more attractive incentives

The challenge for employers of government health workers is to reinstate the administrative systems and re-establish an effective incentives environment

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Rapid emergence of multiple health actors

- During and after conflict, many non-state actors get involved in the health system:
  - International and local NGOs
  - Private sector entrepreneurs.
- Challenge of state capacity to manage a pluralistic system:
  - Trust enjoyed by the state may be low
  - Powerful actors – funders, expatriates etc
  - State capacity to coordinate is usually inadequate to deal with many powerful non-state players.

Challenges for health system leadership

- Non-uniform vision:
  - Short-term vs long-term programming
  - Competition between governance frameworks
    - Project-based Vs System-wide governance
    - State Vs Non-state governance.
- Aid and its effectiveness:
  - Extent of aid alignment to community needs
  - Extent of state building and capacity development
  - Mix of input results and coverage.

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Percival V, MacLean T, Namakula J,Richards E, Ssali S and Theobald S (2013) Building Back Better? Health System Reconstruction and Gender Equality. Final draft report for SIPRI

Gender equity in post conflict contexts: lessons learned

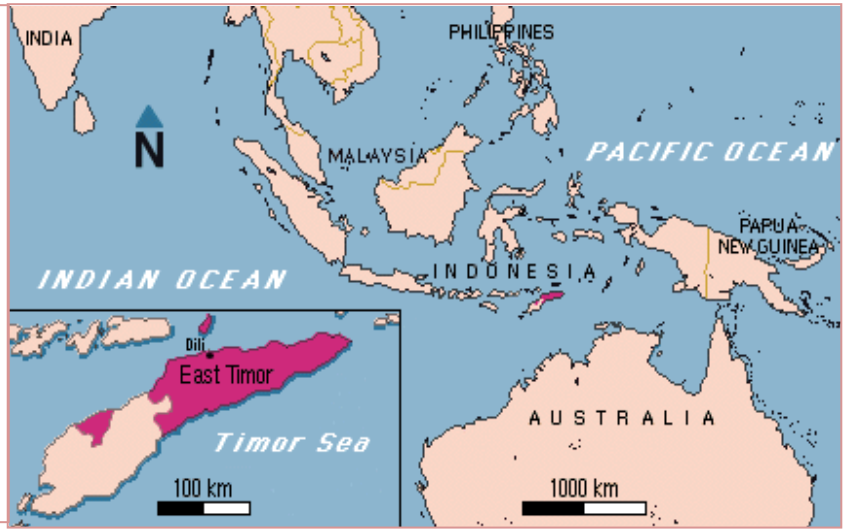
UNSCR 1325

Focus on sexual violence and maternal health

Opportunities missed for broader application of gender equity in reconstruction

Case study: Timor-Leste

Collaboration during transitional period between international and national women's advocates to forward work on gender-based violence specifically e.g. development of a domestic violence law ratified in 2010.



Despite attention paid to gender issues from early stages of health system development - it is unclear whether this has developed much beyond a focus on maternal and sexual and reproductive health.

Case study: Northern Uganda

The health system has been integrated without any form of health reform or reconstruction plan

Humanitarian work on gender has largely focused on gender-based violence in N Uganda. Feelings of male alienation.

Despite advocacy from Ugandan women's groups, the Peace Recovery Development Plan did not incorporate a gender responsive approach.

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Conflict, post conflict health systems and gender equity in Sierra Leone

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- Collapse of government systems preceded conflict and implicated in understanding of it (‘greed’ vs ‘greivance’)
- Failure of IMF interventions in 1970s – no economic recovery; sustained economic mismanagement and corruption
- By 1995 extreme health financing structure: 91% health expenditure private; 95% of that OOP – no social protection from financial risks of ill health; highest burden on poor (Fabricant and Kamara)

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Aid for health implicated in conflict?

- Greed based explanations of SL conflict largely based on diamonds and other minerals
- One analysis supports idea that ‘fungible’ aid is among the prizes fought over (Findley et al., 2011)
- How relatively ‘fungible’ is health aid?

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- 1980s – significant external aid but:
- 31/146 chiefdoms without any government medical facilities; 5-10% of children <5 enrolled in a health clinic (MacCormack, 1984)
- No correlation between service availability and infant mortality rates (Kandeh and Dow, 1980)
- Public health expenditure declined 60% between 1980 and 1987

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National Action Plan for Primary Health Care (date? – 1980s)

- Lacked engagement with political realities
- Attempted to decentralise – conflict with health system power base at provincial level; ignored Chieftancy system
- No powerful local actors supported
- Driven by World Bank

Similar critique post-conflict

'The temptation in post-conflict situations is for a greater degree of international intervention in domestic health policymaking. But such an approach neither builds local capacity nor represents a demonstration of good government. Indeed it may even serve to foster long-term dependency and undermine the government's credibility. If health and medical care is indeed going to be an area in which governments can demonstrate that they act in the interests of the populace and re-establish the social contract it is vital that health policy is made at the national government level, and not in Washington or London.' (Rushton, 2005 p11)

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Major health policy developments since 2010

- Free health care policy (heavily donor dependent; question marks about ownership at local levels at least)
- Large salary uplift (heavily donor dependent)
- Performance based contracts with districts (in early stages of implementation, donor dependent, some national ownership; local attitudes unknown)

Gender equity study

Sierra Leone

- Most recent health sector strategy plan includes a focus on gender equity.

- Document highlights the need to address important gender-sensitive aspects of health such as health-seeking behaviour.

- Performance indicators include few that are gender-sensitive however.

Source: Percival et al. 2013

Quantitative or Qualitative difference?

Quantitatively different (similar problems but worse)

- Inadequate co-ordination, planning
- Dysfunctional IS
- Inadequate management capacity
- Exclusion of population groups
- Lack of referral
- Lack of infrastructure
- Inadequate capacity building systems
- Problems of aid alignment with local priorities

Qualitatively different (different underlying problems)

- Links between the peace process and the health system (positive and negative)
- Discontinuities that for example generate discrete gaps, like a missing age cohort of health workers
- Multiple agency involvement with some different actors (eg humanitarian)
- 2 transitions: humanitarian agencies to development donor dominance; development donors to more normal degrees of sovereignty; longer time scale than recognised
- Gender equity agenda dominated by sexual violence concerns (but also maternal health which might be similar to other settings.