ReBUILD Consortium

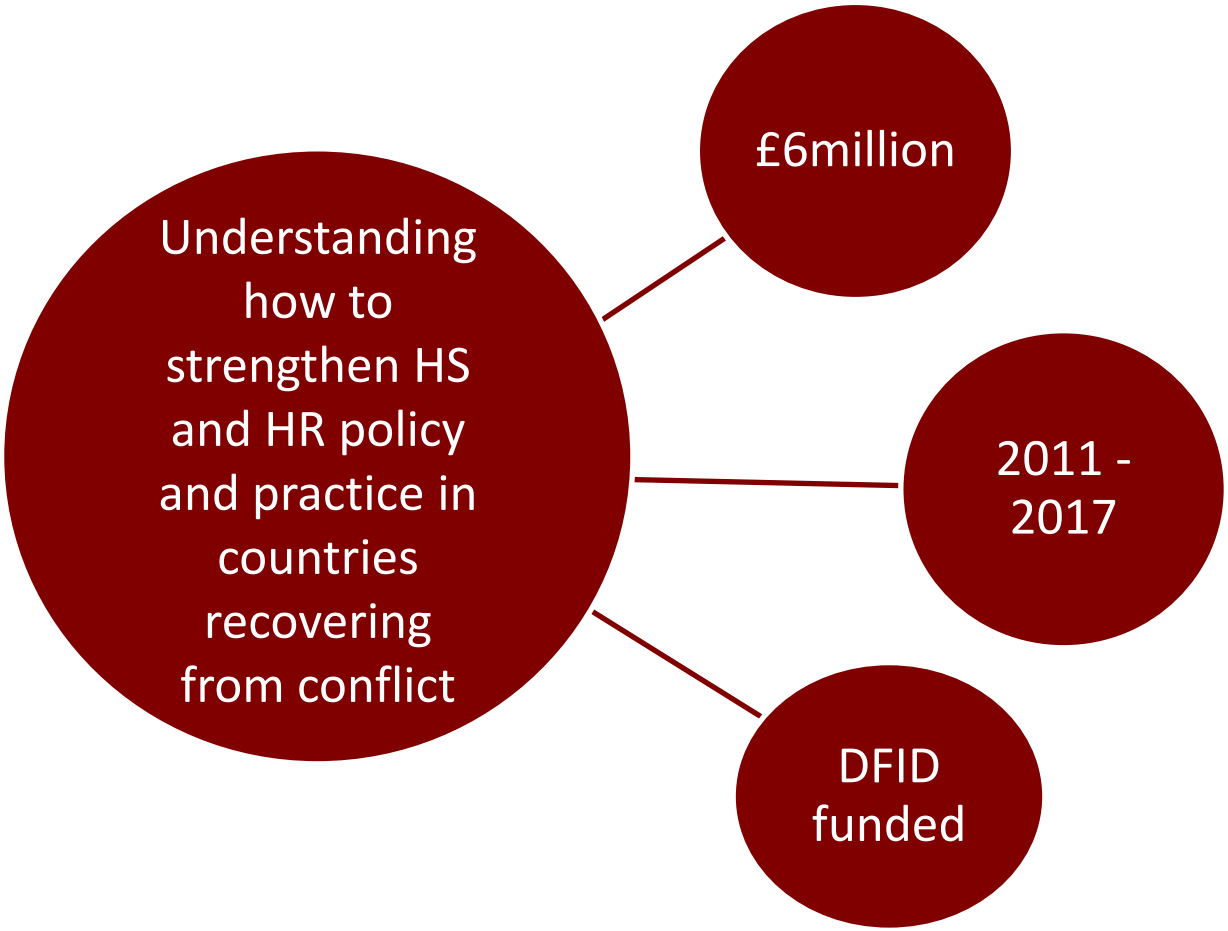
Funded by

UKaid from the British people

Health Systems in post conflict settings

Current work of ReBUILD: Research for Building pro-poor health systems in the aftermath of conflict

What is ReBUILD?



ReBUILD partners

Cambodia (CDRI), Sierra Leone (COMAHS), Uganda (MUSPH), Zimbabwe (BRTI), UK (LSTM) and (QMU).

Key starting points

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

Session content

Post conflict health financing and human resources contexts

- What do we know and what are the gaps?
- Governance and workforce developments
- How HR policy change has shaped staffing, incentives and performance
- How health financing policy change has shaped the burden on the household expenditures of the poor
- (Re)Building gender responsive systems


© 2009 Lindsay Cope, Courtesy of Photoshare

Health financing and human resources in post conflict states: what do we know and what are the gaps?

Sophie Witter & Tim Martineau

Queen Margaret University, Edinburgh &
Liverpool School of Tropical Medicine

Overview

- Rationale & objectives of literature reviews
- Background & cross-cutting topics
- Gaps in existing literature
- Agenda for research for ReBUILD and beyond

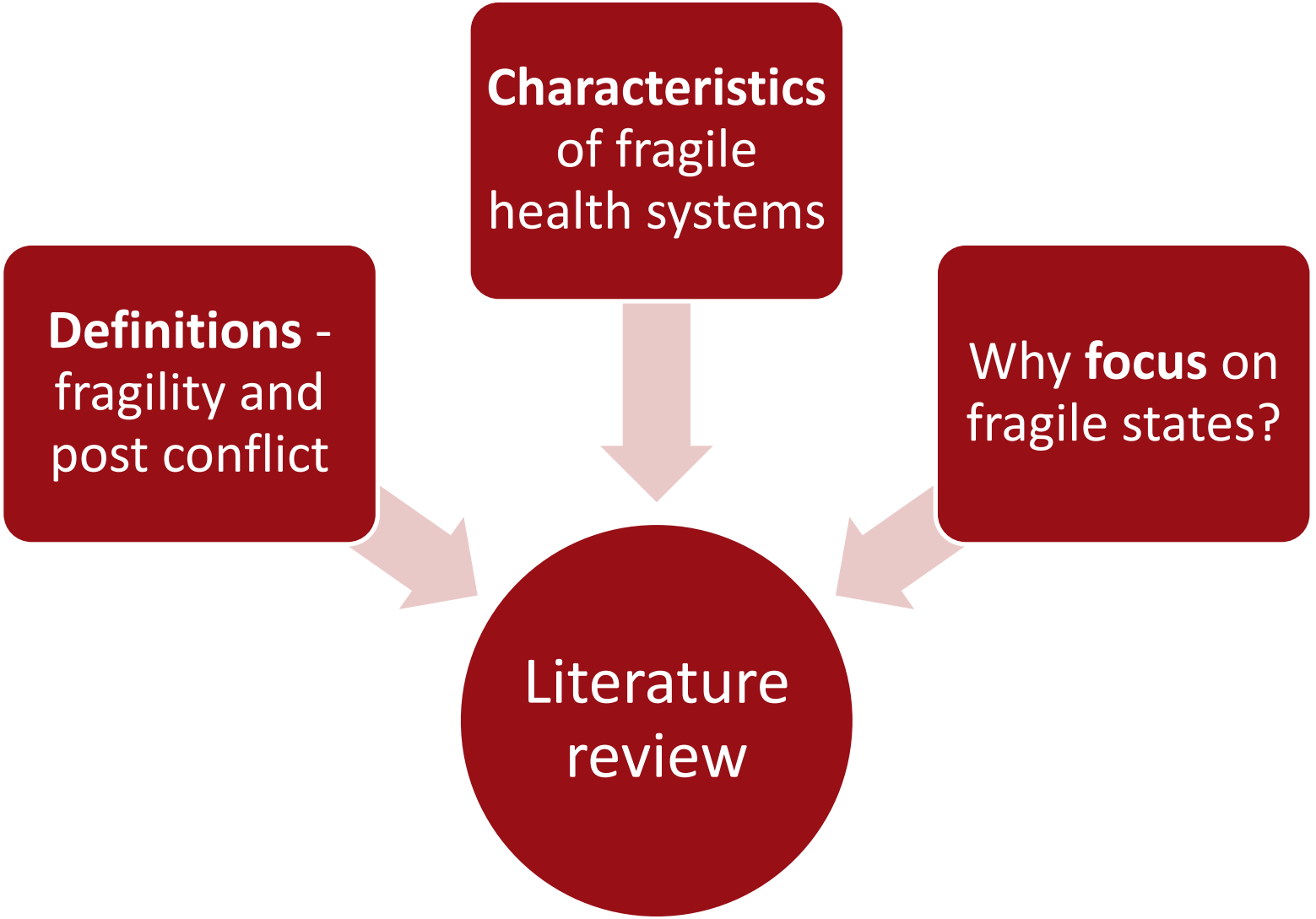
Rationale and objectives

- Baseline for ReBUILD work on health financing & HR
- No literature reviews to date of these topics

Objectives:

- To analyse thinking, approaches, themes and findings of recent writing on health financing & HR in post conflict or fragile health systems
- Study themes analysed against grid to identify areas of focus and gaps

Cross-cutting topics



Definition - 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

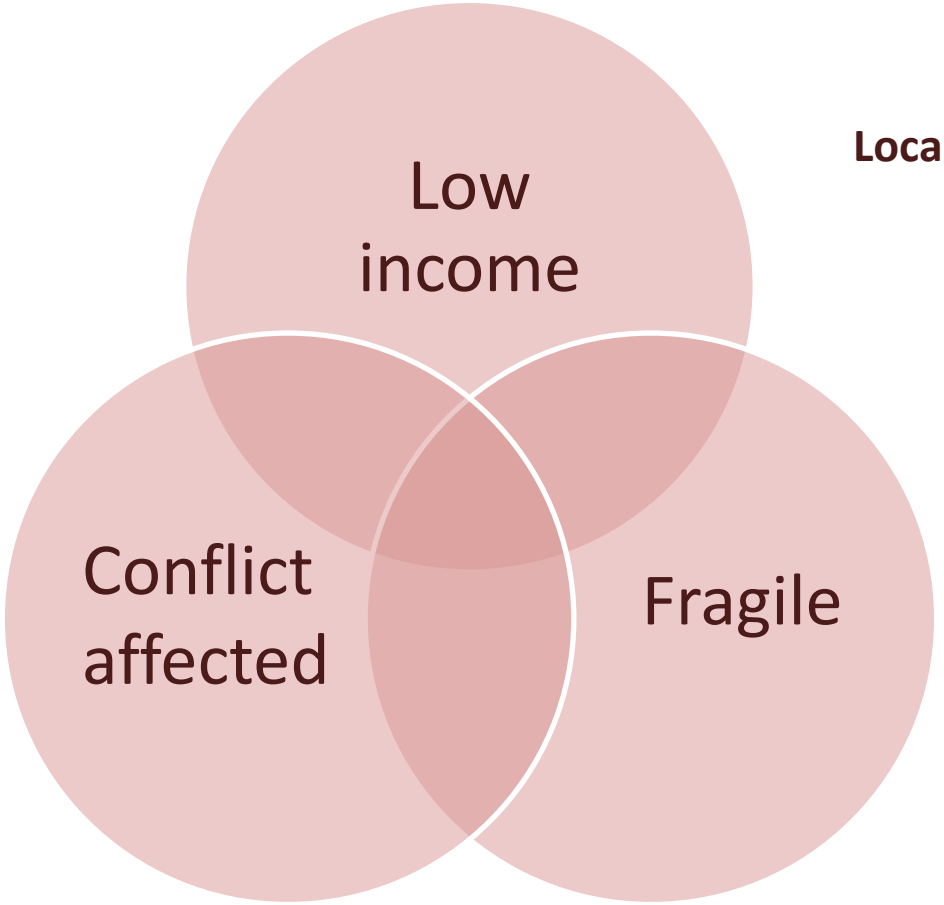
Most countries exhibit some of these characteristics (fragility may be the norm...)

These states are temporary but non-linear

Definitions - post conflict

Repressive governments

Poor governance



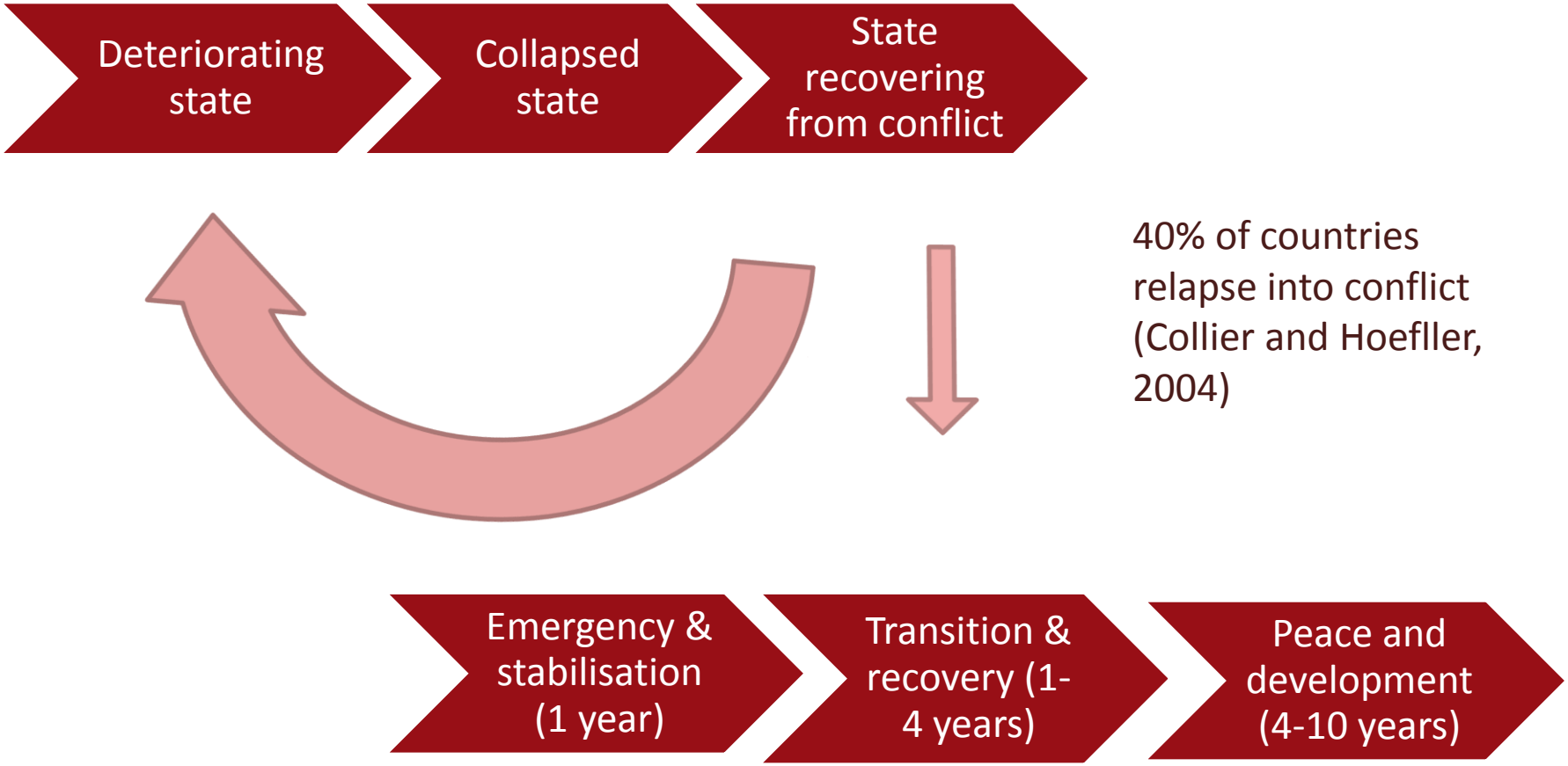
Localized conflict

Chronic ethnic unrest

Economic crisis

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

Different stages



Source: DAC, 2005; Ahonsi, 2010

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 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)

Wider potential benefits

HSS-state building links

Strengthening the capacity of other institutions and sectors

Strengthening citizen interactions at different levels of the state

Encouraging citizen involvement in public life

Over the ***long-term*** improving health outcomes, which reduces poverty and thus, the risk of conflict

Evidence seen as inconclusive though (Eldon et al. 2008)

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

Some outstanding questions (HR)

- What is the impact of the influx of new employers on the health labour market?
- Has the use of task-shifting resulted in a more flexible workforce?
- Are there opportunities for strengthening personnel management systems in the post-conflict period?

Agenda for research

- More longitudinal studies, which examine how decisions taken in the immediate post-conflict period may or may not influence longer term developments
- Understanding how health financing strategies are developed post-conflict and their effects on poor households, on HSS, and on wider state-building
- Topics which have received attention (e.g. contracting, non-state actors, skills mix) could benefit from more rigorous analysis with a longer time and broader perspective
- Some areas, such as PBF and personnel management systems, should be analysed in relation to the post-conflict setting more specifically


2007 Emmanuel d'Harcourt, Courtesy of Photoshare

Health systems governance and workforce developments in post conflict health systems

Freddie Ssengooba

School of Public Health, Makerere University

Context

History of conflict

Northern Uganda experienced violent conflicts since mid **1980s**

Conflict fuelled by factors including resistance to govt, poverty, need to accumulate wealth

Government of Uganda and Lord's Resistance Army enter into peace negotiations **2006**

Gulu district ranked one of top 15 performing districts (MoH **2006**)

Challenges to peace and the health system remain

"In a crisis lies opportunity" JFK

Makerere University, College of Health Sciences

Key messages

Discontinuities in health system functioning influence:

Workforce markets

- Production
- Recruitment
- Available stock

Governance of the health system actors

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

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

What ReBUILD is doing

Study to explore how governance relationships among actors in the post conflict health system in northern Uganda are contributing to aid for health and its effectiveness

Study objectives

- To assess the aid relationships among agencies central to the implementation of selected health services at the district level
- To analyse the major dynamics in aid-relationships and aid effectiveness parameters using social network analysis
- To compare across three districts the inter-agency networks for implementing selected health interventions (maternal health, HIV treatment and workforce strengthening)

Main methods

Prospective case study using mixed methods:

Social network analysis – interagency relationships

- Relationship mapping for the delivery of key services
- Resource exchange and interdependencies

Organisation survey for perceived aid effectiveness

- Using customised indicators of aid effectiveness for the district level
- Capacity of local government institutions (applying health system building blocks)

Child vaccination in Sierra Leone 2011, DFID UK

How human resource policy change in the emergence from conflict has shaped staffing, incentives and performance

Joseph Edem-Hotah

College of Medicine and Allied Health Sciences, University of Sierra Leone

Introduction

ReBUILD's health worker incentives project aims to identify key relevant Human Resource Management (HRM) factors to influence policy in the study countries

Rationale

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

Context

History of conflict

Sierra Leone conflict, during which health sector deteriorated **1991 - 2002**

Dr Ahmed Tejan Kabbah elected as president **1996**

President removed in coup d'état **1997**

International military intervention force ECOMOG* intervened and reinstated the president **1998**

President Kabbah declared the war over **2002**

**Economic Community of West African States Military Observers Group*

Objectives of the Study

- To understand, mainly from the perspective of the health worker, the evolution of incentives for health workers post conflict and their effects on staffing levels and performance
- To identify perceptions and analysis of routine impact on staffing and outputs
- To examine the evolution of the administrative systems to ensure equitable deployment of staff, particularly in rural areas
- To identify changes in deployment policies and the implementing systems

Main methods

Quantitative and qualitative data collection methods

Documentary review	Key informant interviews	In-depth interviews	Life histories	Health worker incentive survey

Findings

- Document and draw on lessons learned in Cambodia, Sierra Leone, Uganda and Zimbabwe for improving their methods of managing staffing levels and performance
- Based on the above, there will also be lessons to learn on HR related decisions for other countries emerging from conflict

Malaria patient in Cambodia 2009, PBS Newshour

How health financing policy change in the emergence from conflict has shaped the burden on the household expenditures of the poor

Neath Net

Cambodia Development Resource Institute

Introduction

History of conflict

Cambodia experienced civil unrest for more than two decades **1970 - 1993**

Peace was assumed when the UN sponsored for a national election in **1993**

Despite the successful election, the fractional fighting was broken up again in **1997**

A tension between the ruling party and oppositional party remained after a national election in **1998**

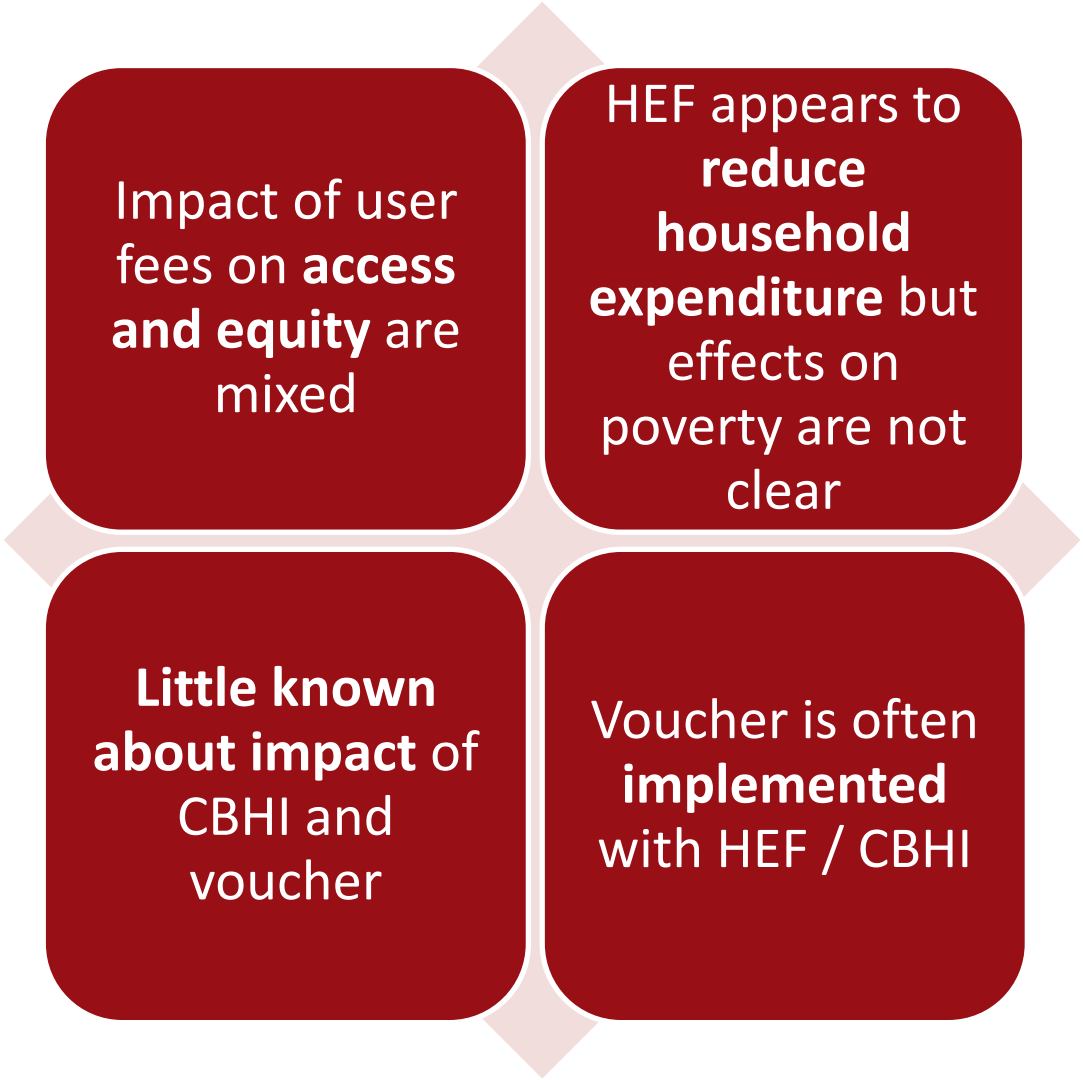
Death of KR leader in **1998**, remaining soldiers begin to defect to the government

True peace began early **1999**

Health system reforms

- The MoH conducted a number of health reforms during the post conflict period including:
  - 1996 Health Financing Charter - allowed public health sector to charge User Fees, with exemption of the poor (not very successful)
  - Health Equity Fund and Community Based Health Insurance targeted voucher and group diseases (TB, HIV/AIDS) – aimed to protect the poor from health costs

Health financing changes and existing evidence



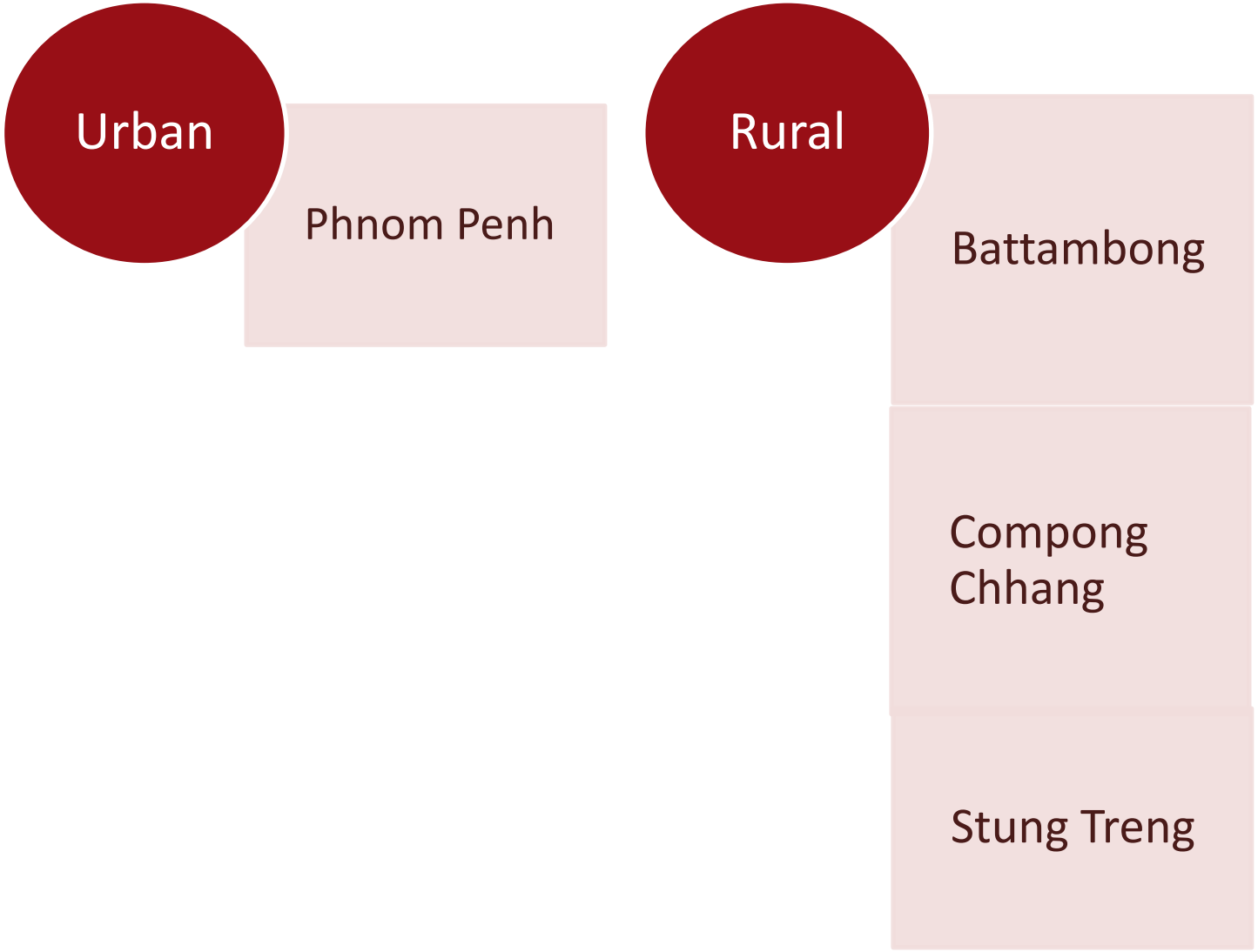
Sources: *Barber et al. 2004; Akashi et al. 2004; Wilkinson et al. 2001; Jacobs and Price 2004; Hardeman et al. 2004; Meessen et al. 2006; Meessen et al. 2004; Jacobs and Price 2008; Khun and Manderson 2008*

Objectives

- To assess the impacts of user fees (UF), health equity fund (HEF) and community based health insurance (CBHI) on household expenditure for the poor
- To identify socio-demographic attributes that may be linked to health expenditure

Timeframe and study sites

Three years (2012 – 2014)



Main methods

Quantitative

- What is to be measured?
- Data
  - Household Survey Data
    - CSES 1997/1999/2004 (User Fees)
    - CSES 2009/2011 (Health Equity Fund/Community Based Health Insurance)
  - Administrative data – User Fees, Health Equity Fund, Community Based Health Insurance
  - Other administrative data - voucher

Main methods

Qualitative

- Life history approach
  - Perception about changes in expenditure for health (poor women and men)
  - Perception about changes in demand for health care
  - Strategies used to deal with health expenditure
  - Perception about equitable access in health care

Preliminary results (quantitative)

What difference have the ***user fees*** made to household expenditure for the poor?

HEF and CBHI results are in progress - expected to be out end of this year

Preliminary results: user fees

- No effect of UF on **household health expenditure**
- No effect of UF or the increase of UF on **health care utilisation**
- No effect of UF on **equitable access** to health care utilisation (first OPD)
- No effect of UF **on poverty** was found
- No effect of UF **on substitutions between food and health expenditure**
- UF does have an effect on **catastrophic payments** when threshold at 10% of total household expenditure

Discussion

No difference between informal and official user fees might have been due to formalising informal charges (MoH 2006, Annear 2008)

Demand for health care is price inelastic

UF often moves in tandem with costs in private or non-medical sectors

The progress of inequitable access to health care was driven by the divergence in living standard not UF per se

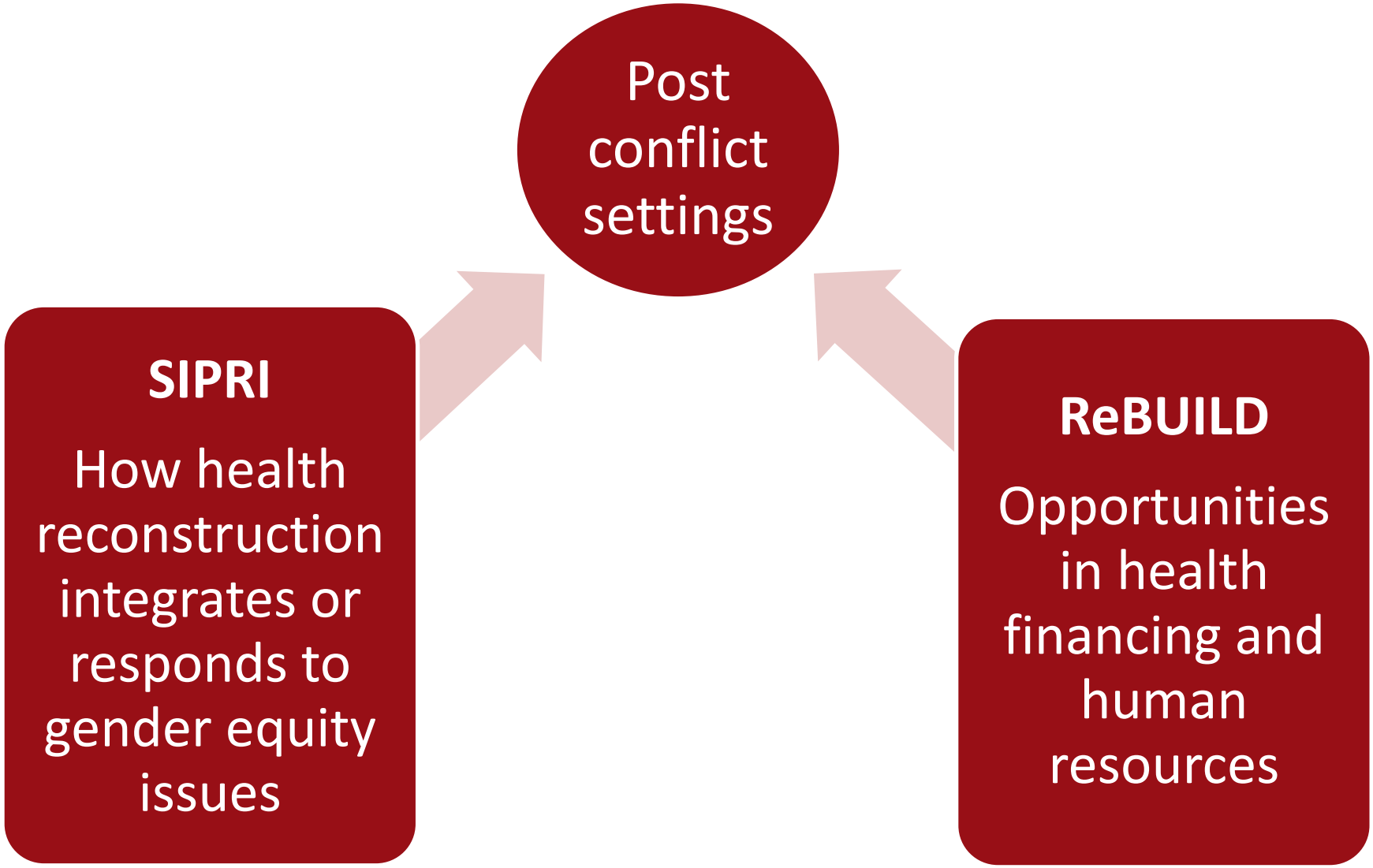

© 2005 Arturo Sanabria, Courtesy of Photoshare

(Re) building gender responsive systems in post conflict contexts

Sally Theobald

Liverpool School of Tropical Medicine

Background and networks



Aim of this stream of work

- To analyse the literature on:
  - Gender and conflict/peace building
    - Member state action plans
    - An analysis of five Consolidated Appeals (CAP)
  - Gender and health systems (post conflict)
- To develop and interrogate case studies to analyse the opportunities and challenges for building a pro-poor gender equitable health system in post conflict reconstruction

Opportunities and challenges

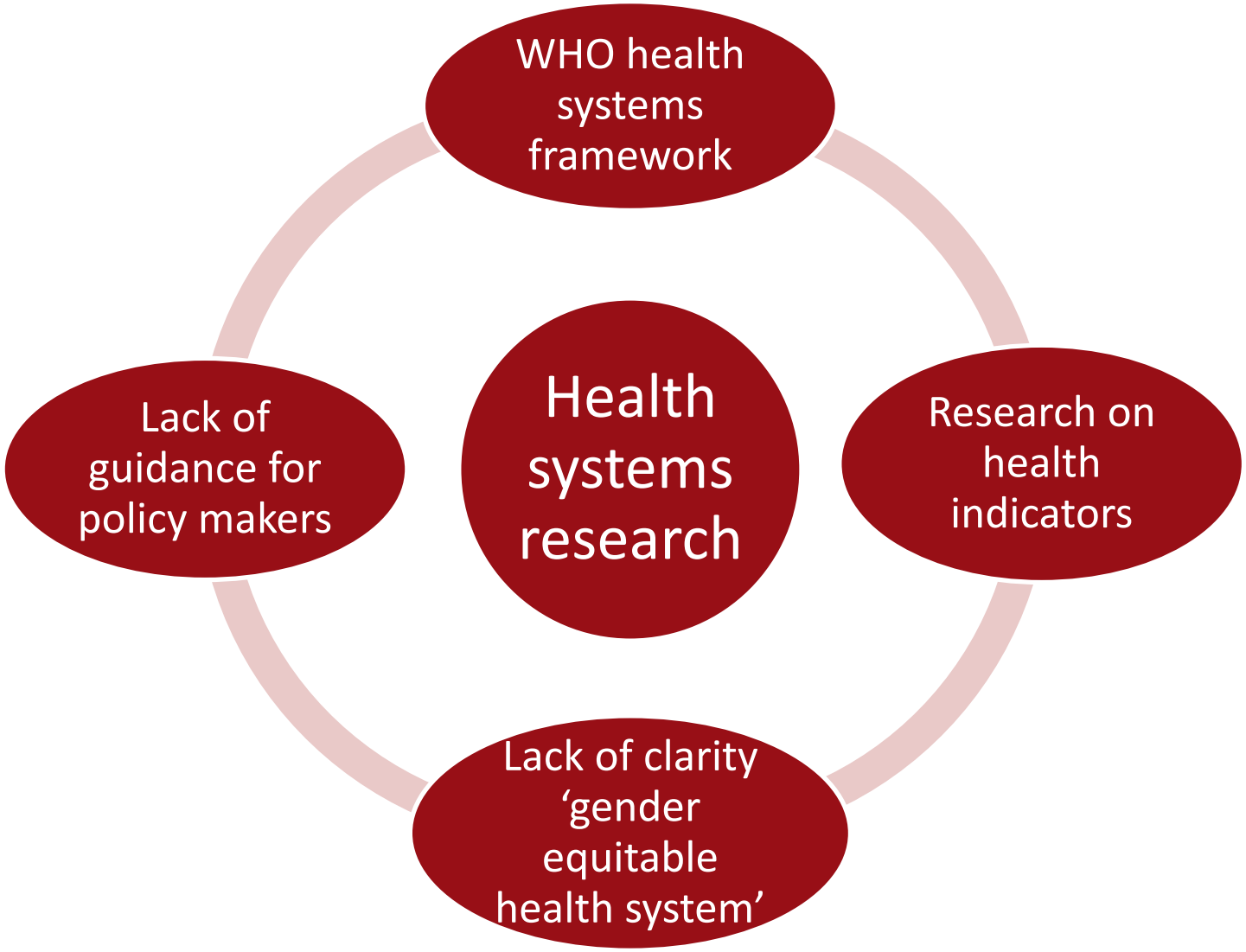
Gender equity in post conflict contexts: lessons learned

UNSCR 1325

Focus on sexual violence and maternal health

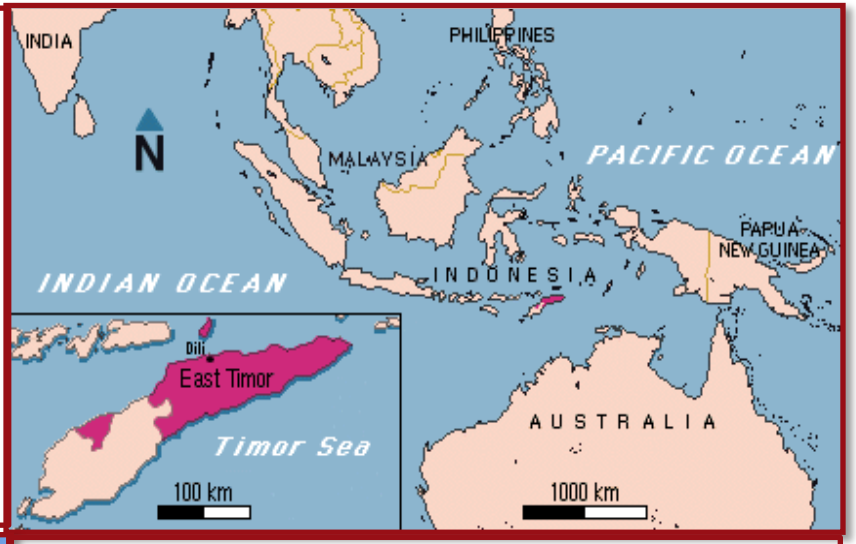
Opportunities missed for broader application of gender equity in reconstruction

Lessons learned (cont)



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

Humanitarian work on gender has largely focused on gender-based violence in Northern Uganda.

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

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

Ongoing investigations

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

Mozambique

- Sustained advocacy following Beijing 1995 led to significant gender-sensitive reforms during late 90s and early 2000s
- Gender machinery has facilitated some important moves to collect and use gender-disaggregated data to analyse aspects of health system performance and identify specific gender issues

Conclusion

- Learning from country cases can provide valuable insight into the opportunities and challenges for gender mainstreaming
- Intersectional approach
- Move beyond broad-defined indicators on maternal mortality &SGBV and develop better understanding of the interaction of various health system elements from a gender perspective
- Women, Peace and Security Action Plans to expand scope to promote female participation in sectors such as health

Acknowledgements

For gender stream:

- Val Percival, NPSIA/Carleton, coordinator, analysis/integration of research
- Tammy Maclean, LSHTM, Literature Review
- Esther Richards, REBUILD, LSTM, Timor-Leste case
- Justine Namakula, REBUILD, Makerere University, Northern Uganda case
- Sarah Ssali, REBUILD, Makerere University, Northern Uganda case
- Francelina Romão, Mozambique Ministry of Health, Mozambique case
- College of Medicine and Allied Health Sciences, REBUILD, Sierra Leone case
- Stockholm International Peace Research Institute (SIPRI), Gender Working Group

Thank you!

2009 Psychosocial support group in Zimbabwe, DFID UK