‘Leaving no one behind’: protecting vulnerable groups in fragile and conflict-affected situations

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Introduction


Bonthe Island, Sierra Leone

Vulnerable groups, such as people with disabilities (PWD), the chronically ill, women-headed households and older people, are profoundly affected by war and political and economic crisis. Their needs are often overlooked and/or neglected and, even at the end of war or crisis, many continue to experience multiple vulnerabilities.

Rebuilding health systems in such situations often includes commitment to address health equity goals, but given other priorities post-conflict, these are often left unfulfilled. Linking health equity with social protection instruments, including fee waivers, targeted cash transfers and subsidies, may boost people’s resilience.

As part of a study on rebuilding health systems following conflict or crisis, life histories were undertaken to explore people’s experience responding to their and their families’ health needs before, during and after conflict, including coping strategies used and presence of beneficial social protection policies.

Aim

This study sought to understand:

- How health care seeking changed over time and in changing contexts
- The strategies households used to cope with the overall burden of health costs
- How evolving financing arrangements impacted on household perceptions of care
- The substitutions made in household budgets (e.g. food expenditures, levels of indebtedness)
- What social protection mechanisms were effective in assisting respondents.

Methods

- Life history interviews with household heads (adults age 40+) in Cambodia, Northern Uganda, Zimbabwe, and Sierra Leone
- Semi-structured interviews with key informants (district leaders, officials and service providers in Northern Uganda and Zimbabwe)
- Document review
- Study sites represented urban/rural variations and varying degrees of remoteness and poverty.

Respondents drew a timeline of events pre-, during and post-conflict describing illness episodes and health seeking behaviour for themselves and other household family members, as well as how they paid for and coped with health care costs [Figure 1].

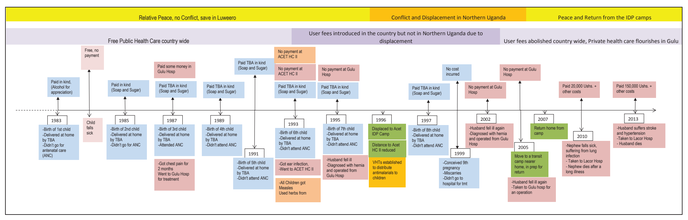

Figure 1: Example of Life History Timeline (N Uganda)

Findings

1) Respondents and their families’ illnesses reflected their life course. Many of their children died from preventable childhood diseases; malaria and other communicable diseases were common; and injuries frequent. As they grew older, most respondents developed multiple chronic conditions, reflecting their age, that require routine monitoring and regular medication. Many currently experience mobility and visual impairment.

Figure 2: Trajectory of illnesses reflecting life course

“…When my children begun dying I went through a lot of problems; I buried six of my children in the same period, I became worthless. …Six children died, there was an outbreak of measles during the war and it called all of them.” ***(N Uganda, F, 63).***

2) Many reported **limited provision of formal health care pre- and during conflict, and relied heavily on informal and traditional health care**. The public sector was unavailable or unaffordable. All respondents reported increased use of public health facilities post-conflict/crisis, but with continuing difficulties in meeting health care and related costs.

“I suffered from the hepatitis… I went to a traditional healer in my Sangkat. I just gave him a small sum of money to show my gratitude. But, I have spent a lot with the Kandieng traditional healer…” ***(Cambodia, M, 74).***

3) Households used the following strategies to cope with health costs:

- Delayed treatment and reduced or shared drug doses
- Cutting back on food consumption
- Sale of assets – land, livestock, vegetables, household and personal belongings
- Borrowing – used assets as collateral
- Piece work
- Petty trading
- School fees unpaid

“…when these costs become too expensive for us, we resort to buying drugs from the drug shops and even taking under-dose because we cannot afford health care….” ***(N Uganda, F, 51).***

“…Sometimes I have to do some piece jobs in people’s fields in order to raise money for medications. Now I am skipping hospital visits to avoid paying consultation fees.” ***(Zimbabwe, Makoni, F >45).***

4) Health is compromised without adequate social protection. Many people reported that, during harsh times, **their main support came from social capital and community-based support rather than formal social protection mechanisms.**

“Family members can come together and contribute money for healthcare if a member of the family does not have money at that time.”
(Sierra Leone, Kenema, M, 52)

Informal social protection ⟷ Formal social protection

Social capital – family, friends	**Fee exemptions:** Sierra Leone and Zimbabwe
Community level support – religious organisations	**Fee waiver for under 5s/pregnant and lactating women:** Sierra Leone (FHCI)
	Free health care: Northern Uganda
	Subsidies: Cambodia - Health Equity Fund (HEF); Zimbabwe - Assisted Medical Treatment Order (AMTO)
	Social insurance: Cambodia - Community-based health insurance (CBHI)
	Cash transfers: Cambodia and Zimbabwe – social pensions

The formal mechanisms shown were either not available or less reliable: exemption policies in Sierra Leone and Zimbabwe were inadequately funded and rarely enforced. For many, the costs of drugs, transport, food etc. were still largely out-of-pocket. The AMTO in Zimbabwe has declined in effectiveness due to severe underfunding in recent years, leaving chronically ill and elderly people without adequate protection. The exception was the HEF in Cambodia, which covers many of these costs for vulnerable groups. The FHCI in Sierra Leone and social pensions for the elderly in Cambodia and Zimbabwe were welcomed but under-resourced.

“... this [HEF] card helps a lot. Without it, we would have died, and we would not know what to do when we were sick…I can live until today because of this card. …Without this card, we would have had no money to pay for medical care. ***(Cambodia, M, 51).***

Conclusions

In these fragile environments, the elderly and chronically ill were particularly hard hit having few resources, poor mobility, and declining social networks.

Synergies across health and social welfare sectors contribute significantly in bolstering the coping capacity and resilience of vulnerable groups. Policy coherence across social protection systems can enhance resilience of vulnerable groups, matched by adequate external and domestic resources.

Recommendations

- Expand formal social protection mechanisms to complement informal arrangements,
- Ensure they are adequately and sustainably funded,
- Ensure social protection policies are in line with individual needs at different points throughout their life course,
- Ensure social protection policies address multiple chronic conditions and medication needs.

References

All resources on ReBUILD’s work can be found at **www.rebuildconsortium.com**

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