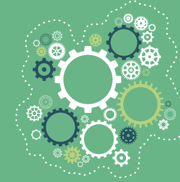
ReBUILD Consortium

Research for stronger health systems post conflict

Institutions for strong and equitable health systems after conflict and crisis: lessons from ReBUILD research



Background

Whilst the main focus of ReBUILD's research was on two health systems themes – health financing and health workers, the general theme of institutions – that is, the organisations, rules and relationships affecting the health system – cut across these.

This brief outlines selected issues related to **institutions** highlighted by ReBUILD's research including the implications for local, national and international actors and their roles and approaches in health systems strengthening after conflict or crisis. The brief starts with the actors and networks involved in the post-conflict context and the distribution of power. Next the policy response to the post-crisis situation is reviewed. The responsiveness of the policy and influence of actors has an important role in determining resource flows and ultimately who benefits from them. Finally, building on individual and institutional capacity is essential.

Actors, networks and power

The transition from emergency to post-conflict or post-crisis is a time of immense change and opportunity, often lacking in policy clarity, implementation capacity and resources. At one point during the conflict in northern Uganda, for example, there were over 300 health-related organisations[1]. Changing roles and identities of institutional actors in the transition from emergency to post-conflict is also commonly experienced - from humanitarian actors to state actors and development-oriented international NGOs and donors.

A lack of coordination amongst the actors may lead to a chaotic situation, as one respondent from Sierra Leone explained:

> "After the war, it was complete chaos. The NGOs came and went […]. They employed the nurses directly, without even consulting the Ministry. […] They never presented any budget. But this was a war. We had to bend backwards in the Ministry"

(Ministry of Health official, Sierra Leone)[2]

New networks and relationships are established between these diverse actors, often with different priorities and approaches to rebuilding health systems post-conflict, increasing the potential for fragmentation in the system. This approach can lead to an unhelpful power imbalance between those with resources and the recipients at national and sub-national levels. Research in Sierra Leone illustrated the power dynamics between the District Health Management Teams (DHMT) and donor-funded NGOs in the post-conflict period:

> "Providing the DHMT with in-kind donations (vehicles, motorbikes, fuel, communication means, etc.) or cash allowances to support its tasks, or at least those that match the NGO's objectives and scope (geographical, disease-wise, mission-wise, etc.), becomes a bargaining tool to ensure the smooth running of both NGO and DHMT activities."

(DHMT member)[3]

Key points:

- In the post-conflict/crisis periods, many national and international actors may arrive to support provision of health care. However services can be uncoordinated and those with power may usurp the prioritisation, coordination and longer-term planning roles of local actors, including ministries of health.
- New policies must be responsive to the changed needs of the population after conflict or crisis. Opportunities may occur when a number of factors are in place, but these 'windows' may not occur until some time later.
- Resource flows may be unpredictable where coordination is weak, and disrupt health system performance. Planning for equitable dispersion is needed.
- Both local individual and institutional capacity is essential for rebuilding health systems. It is often present, though risks being undermined if it is not appropriately understood and supported.

[1] See Ssengooba et al (2016). Application of Social Network Analysis in the Assessment of Organizational Infrastructure for Service Delivery: A Case Study from post-conflict Northern Uganda. Draft Working Paper., Report for ReBUILD. p3. Available at http://bit.ly/2fpF85U.

[2] See Witter et al (2012) Health worker incentives: stakeholder mapping report (Sierra Leone). Report for ReBUILD. Available at http://bit.ly/2glrpKf.

[3] See Bertone, M. P. and S. Witter (2015). "An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone." Social Science & Medicine 141: 56-63. Available at http://bit.ly/1E7P2dC.

Actors, networks and power

Rebuilding can obviously be a challenge where for example capacity and systems have been completely decimated. At the end of the conflict in 1990 Cambodia had only 25 of its original stock of 450 doctors and completely broken health systems[4]. It was therefore understandable that external agencies played a major role in rebuilding the health systems in the country, including the provision of health services by contracting international NGOs. Operating costs of NGOs were high and national management capacity was not being developed. It was not until 2009 – nearly 20 years after the end of conflict that the government and local managers took back full control of service delivery, including through the establishment of Special Operating Agencies (SOA). In contrast, we found that in countries where there was no break in regime moving from conflict/crisis to the post-conflict/crisis period – such as Zimbabwe – national agencies remained in control[5].

Responsive policy

Life histories in our studies have shown that the vulnerabilities of many groups, such as people with disabilities, orphans and older people are often more pronounced post conflict. Gender roles and relations are affected: for example, for women, widowhood compounded their war suffering, loss of property, displacement and family disruption. The end of conflict may provide opportunities to reconfigure health systems in a pro-poor direction.

However, the opportunity may not occur in the immediate post-conflict period due to low national capacity and a lack of coherence due to the presence of multiple external actors, including humanitarian and development agencies. In Sierra Leone the 'Free Health Care Initiative' was launched eight years after the end of the conflict only when there was strong political support and a more cohesive and supportive donor community[6].

Policy may not be responsive at all. Our analysis of gender in post conflict health systems reconstruction in northern Uganda[7] showed limited support to survivors of gender based violence (with male survivors particularly neglected), with much more attention paid to the hardware of health infrastructure (e.g. building clinics) over the 'software' of health approaches, including strategies to ensure vulnerable groups can access care.

The lack of national capacity and ability to lead change may also lead to policy being externally driven resulting in poor local ownership leading to weak policy implementation. Progress towards greater national ownership of policy can be slow and is not linear – dependence on external financing established in the early post-conflict period can increase over time, for example, not diminish.[8]

Resources flows

In post-conflict situations, significant flows of resources to the health system may commence once the signals of peace arrive. To be effective in the recovery of the health system, these flows need to be coordinated and scrutinised by domestic actors, who are accountable for allocative decisions. While domestic institutions are typically weak post-conflict, supportive and sensitive partnerships can help to build their capacity over time to direct and manage flows, as evidenced by the health system reconstruction in Cambodia.[4]

Our work in northern Uganda used social network analysis to understand the relationships, and more specifically the resource flows, across the many agencies involved. The study showed that resource flows can be unpredictable and beyond control of local health managers leading to future vulnerability.

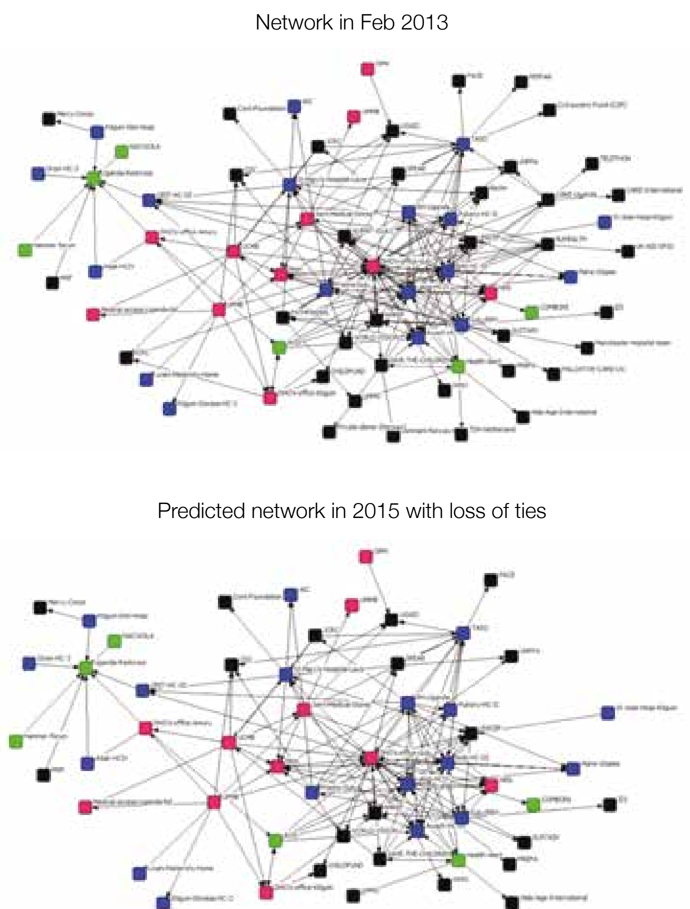


Figure 1. Predicted change in health service delivery network in Gulu District from 2013 to 2015

[4] So, S. and Witter, S. 2016. The evolution of human resources for health policies in post-conflict Cambodia: findings from key informant interviews and document reviews. ReBUILD RPC Working Paper. p17. http://bit.ly/2fbKWwC.

[5] Witter, S., Bertone, M., Chirwa, Y., Namakula, J., So, S., Wurie, H. (2016) Evolution of policies on human resources for health: opportunities and constraints in four post-conflict and post-crisis settings. Forthcoming with *Conflict and Health*.

[6] Witter, S., Wurie, H. And Bertone, M. (2015) The Free Health Care Initiative: how has it affected health workers in Sierra Leone? *Health Policy and Planning journal*, 1-9 Available at http://bit.ly/2fCvGY7.

[7] Percival, V, et al. "Health systems and gender in post-conflict contexts: building back better?" *Conflict and Health* 8.1 (2014): 1. Available at http://bit.ly/2gA7Le0.

Figure 1 shows the predicted loss of 16 organisations from Gulu District with less than 2-year commitments in 2013, many of them fund-holders, which could have affected 69% of the 'ties' (relationships or interactions) in the network if not replaced. Such changes could leave major resource gaps that cripple the performance of a health system. A more resilient system would be based on more robust networks.

Rebuilding the health system equitably requires allocating resources on the basis of population and geographical need, rather than ease and availability of capable organizations in the area, a situation often experienced in many post-conflict countries. Frequently, the districts and services already well established receive intensified resource flows post conflict, as was seen with the establishment of SOAs in Cambodia[9]. Willingness to engage in a strategic, longer-term plans for equitable resource flows that will leverage the mid to longer term development of the health system will have a positive effect on system resilience.

Building individual and institutional capacity

In spite of the devastation health systems suffer as a result of conflict and crisis, they can demonstrate remarkable resilience. Many health workers continued working during the conflict in northern Uganda[10]. Local managers did their best to support health workers in northern Uganda and Zimbabwe. Examples of good practice in maternal health care were identified in Cambodia[11].

Group Model Building with health system stakeholders in conflict-affected Northern Nigeria[12] also identified positive practice within the health system (see Figure 2).

There were two major pathways of threat to quality of care identified: one related to the migration of people across the state (blue line) and the other the erosion of human resource capacity (purple line). Adaptions to these threats involved three major pathways. Political will leveraged financial and other resources to improve HR capacity and strengthen access to medicines (red line). Community cohesion enabled improved coordination with security forces, facilitated access to services and prompted political engagement (pink line). Staff commitment (orange line) – particularly amongst indigenous staff – strengthened quality of care directly and also indirectly through enhancing HR availability with flexible working.

It is important, therefore, to ensure that where individual or institutional capacity exists, external actors avoid

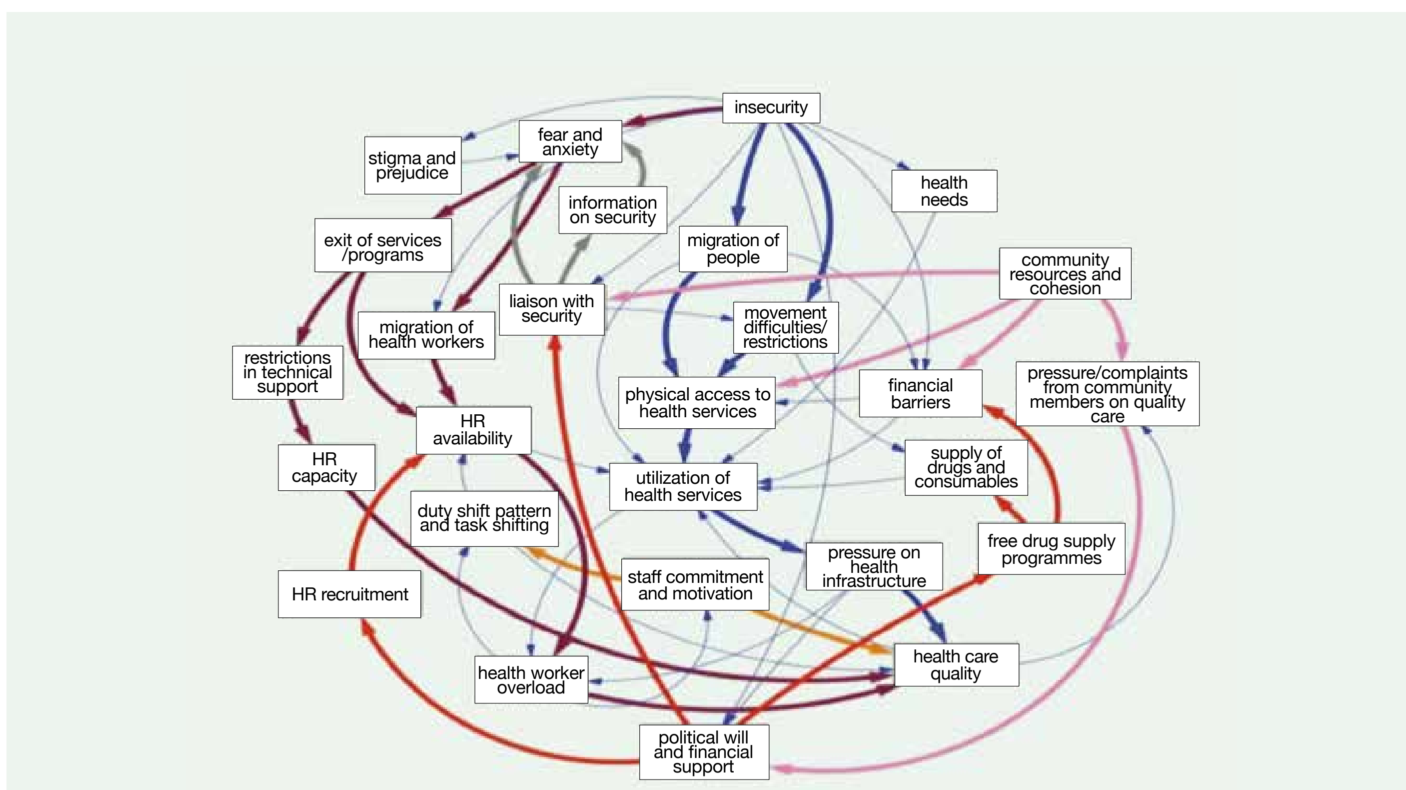


Figure 2: Causal loop diagram developed with health system stakeholders in Yobe, Nigeria

[8] See Witter et al (2016) Evolution of policies on human resources for health: opportunities and constraints in four post-conflict and post-crisis settings. Forthcoming with Conflict and Health

[9] See Vong, S., J. Raven and D. Newlands (2015). Understanding Contracting in Cambodia. The performance of contracting and non-contracting districts in extending primary health coverage: analysis of secondary data. ReBUILD RPC Research Report. Available at http://bit.ly/2gAarYS.

[10] See Namakula, J. and S. Witter (2014). "Living through conflict and post-conflict: experiences of health workers in northern Uganda and lessons for people-centred health systems." Health Policy Plan 29 Suppl 2: ii6-14. Available at http://bit.ly/2eyG6YZ.

[11] See Le, G., M. Heng, K. Nou, P. So and T. Ensor (2016). "Can positive inquiry strengthen obstetric referral systems in Cambodia?" The International Journal of Health Planning and Management. DOI: 10.1002/hpm.2385. Available at http://bit.ly/2g876lQ.

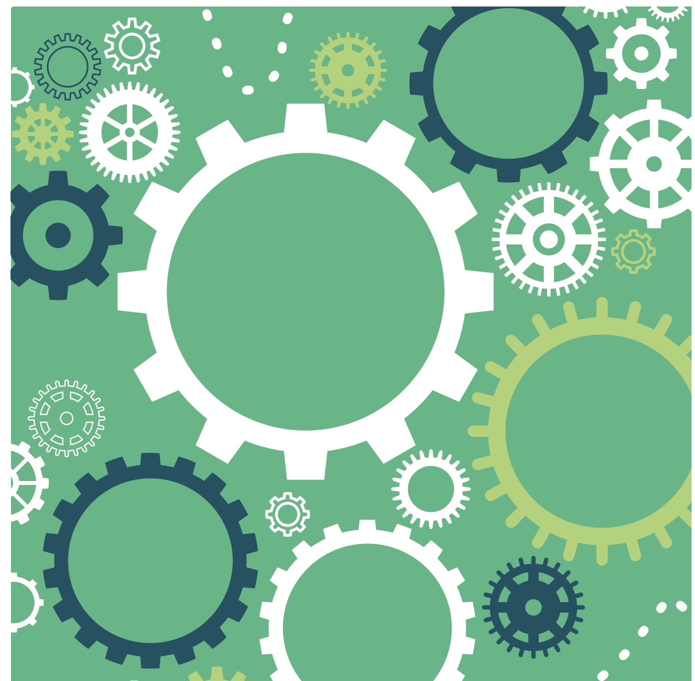
undermining it inadvertently. Observations from Sierra Leone, 2002-16, suggest that support has not built capacity in the Ministry of Health and Sanitation (MoHS) effectively, due to external factors including: unpredictable funding and short-term focus; poor coordination between donors; over-reliance on external technical assistance; by-passing of the MoHS; brain drain of staff; the disruptive use of per diems; and capacity building which is focused on individuals, not institutions[13]. Important internal factors, included: chronic under-funding; failure to reform; poor terms and conditions for staff in these institutions; systemic weaknesses, e.g. in financial management; failure to develop strong institutional vision and leadership; and unwillingness to decentralise functions like human resource management.

Conclusions and recommendations

The implications from our findings related to institutions for local, national and international actors and their roles and approaches in health systems strengthening after conflict or crisis are:

- All actors working in post-conflict or post-crisis settings should aim to support the development of sustainable health systems, and be aware of and address possible unintended consequences of their actions that might undermine this goal.
- Local actors should be included in policy development and implementation, and as soon as possible, and should be supported to take a leadership and coordination roles at national and sub-national levels, to ensure local ownership and individual and institutional capacity building.
- Conflict exacerbates multiple vulnerabilities and there is need to ensure the policies developed in the post-conflict/crisis phase build health systems to support gender equity and access to those in greatest need.
- Tools such as social network analysis and group model building may be useful for understanding the dynamic situation in the post-conflict/crisis period.

The ReBUILD Consortium is an international research partnership working on health systems strengthening in post-conflict and post-crisis settings.



Resources

- All reports and articles from ReBUILD's research can be accessed via **www.rebuildconsortium.com**

- For ReBUILD's resources on gender and post-conflict health systems, see **www.buildingbackbetter.org**
- For further information, contact rebuildconsortium@lstmed.ac.uk or Nick Hooton (**nick.hooton@lstmed.ac.uk**)

All quotations are from respondents interviewed as part of ReBUILD's research.

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[12] Ager, A. K., M. Lembani, A. Mohammed, G. M. Ashir, A. Abdulwahab, H. Pinho, P. Delobelle and C. Zarowsky (2015). "Health service resilience in Yobe state, Nigeria in the context of the Boko Haram insurgency: a systems dynamics analysis using group model building." Conflict and health 9(1): 1 Available at http://bit.ly/2gA5BuH.

[13] Witter, S. 'Can donors really build institutions?' Panel presentation at World Bank Fragility, Conflict and Violence Forum, March 2016. Available at http://bit.ly/2g8chC7.