ReBUILD Consortium

Research for stronger health systems during and after crisis

Health systems during and after crisis: evidence for better policy and practice | Brief 2

Developing inclusive health systems in crisis-affected settings

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It is widely recognised that health systems should aim to ensure fair access for everyone to health and healthcare.[1] This sentiment is key to 'leaving no-one behind' in progress towards the Sustainable Development Goals, yet the design and practice of many health systems discriminates based on social characteristics such as gender, (dis)ability, age, ethnicity and class. Such discrimination exacerbates poverty and causes increased vulnerability and delays in accessing care, in turn leading to worse health outcomes. This policy brief highlights the ways in which health systems reinforce the marginalisation of some social groups, and then summarises the effects of crises on inclusiveness and the interventions that can protect and enhance equity for those marginalised.

Patterns of inclusion and exclusion

An equitable health system is one in which access to healthcare is based on need.[1] However, health systems are social institutions in which access and experiences are determined by a complex set of social factors and relations.[2] Patterns of social exclusion – in which rights and entitlements are systematically withheld from particular groups – play out through the ways in which people are categorised by others as ineligible for good quality, if any, care.[3] This is often part of a wider context in which those same people are excluded from other forms of social protection such as government education and food programmes.

Common barriers to seeking healthcare include lack of formal documentation, the costs and opportunity costs involved including inability to pay formal or informal fees, and limited literacy or proficiency in prevailing languages. Such requirements are particularly problematic for marginalised groups who lack the financial and social resources to navigate document application processes, pay healthcare fees and in some cases learn the language of healthcare provision. There are similar barriers for employment within health systems as some social groups face systematic discrimination and exclusion from specific types of work.[4]

Key messages

- Achieving the goals of universal health coverage and 'leaving no-one behind' requires increased resources and attention on promoting equity and inclusive approaches in contexts affected by crises.
- Key to this is developing and monitoring policies and plans that are responsive to the health needs and realities of marginalised (and often traumatised) genders, (dis)abilities, ages, ethnicities and classes.
- This requires fair financing, and health systems approaches, methods and monitoring and evaluation strategies to ensure these groups can access quality health services that reflect their needs.
- Ensuring the health workforce is appropriately supported to provide inclusive geographic coverage of health services is also critical. Community health workers who are often the main visible face of health systems in rural areas are arguably particularly important, yet little is known about how best to support and sustain this critical cadre within conflict-affected settings.
- Other evidence gaps include best practice for inter-sectoral action to promote equity and inclusiveness during crisis.
- Crises can also bring transitions and the health sector, including health workers, if appropriately coordinated, resourced and supported, can be powerful players in promoting inclusive and equitable health systems.

All the briefing papers in this series can be accessed at http://bit.ly/2rUPRH9

This briefing paper series has been developed by the ReBUILD Research Programme Consortium to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a research agenda-setting study carried out by the Health Systems in Fragile and Conflict Affected States Thematic Working Group of Health Systems Global.

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Gender is a leading determinant of inputs and outcomes for health systems.[5] Women, men, trans and other genders have a spectrum of identities that they ascribe importance to, varied approaches for seeking healthcare, and different burdens of disease. Intra-household dynamics reinforce those differences as some members, often men and older women, dictate access to healthcare for other members.[6] Table 1 outlines a proposed definition of a gender-equitable health system. Intersectionality analyses have growing traction and have revealed how gender interacts with other social and demographic factors to shape access to services.[6, 7] In many contexts, such as post conflict northern Uganda, older women from poor and marginalised communities face the most barriers to healthcare and other forms of social protection.[8]

A gender equitable health system would:
Provide health care services that address the most urgent health care needs of men and women across their life span in an appropriate manner
Ensure men and women across their life span can access and utilize those services unimpeded by social, geographic and financial barriers
Produce relevant, sex-disaggregated health information that informs policy
Ensure equitable health outcomes among women and men, and across age groups
Provide equal opportunities for male and female health professionals working within the health system

Figure 1. What would a gender-equitable health system look like? (Adapted from Percival et al., 2014. **http://bit.ly/2pH5SE9**)

How do crises affect equity in health systems?

Crises weaken protection from the financial costs of accessing healthcare **(see accompanying briefs from this series on health systems resilience and on universal health coverage in crisis-affected settings)**.[9] Government revenue may fall and health financing systems may become disrupted, leading to the emergence of formal and informal systems of user fees. This exacerbates the exclusion of people based on their ability to pay and is felt particularly acutely by marginalised groups. For example during the post-crisis period in Uganda the withdrawal of international non-governmental organisations (and their free healthcare services) meant communities were increasingly reliant on fee-paying services provided by a wide range of for-profit and not-for-profit providers. Woman-headed households, who were poorer and therefore less able to pay user fees, were particularly hard hit.[8]

Marginalised groups are also particularly vulnerable to the negative effects of shifts in social roles, health-related practices and disease burdens that take place during crises. In these settings, disruption to social structures alters gendered expectations of masculinity and femininity, while limited law enforcement and the collapse of social order leads to sexual violence, often perpetrated against all genders.[10] This leads to substantial changes in mental and sexual health disease burdens for marginalised communities, alongside the emergence and re-emergence of communicable diseases and trauma injuries. Health systems need to be responsive to the changing, and often exacerbated needs, of women, men, girls, boys and people of other genders.

Equity in the health workforce is also important in order to maintain an adequately staffed and motivated healthcare workforce, and this is particularly difficult in crisis-affected settings due to the personal risks and professional challenges faced by workers **(see accompanying brief on resilience in health systems).** In Afghanistan, women midwifery students avoided training posts in areas where they were warned they (as women workers) would be specifically targeted for killing,[11] while women community health workers reportedly left their posts due to similar fears over insecurity.[12] Sexual violence perpetrated against (mainly female) community health workers emerged as a key issues in a webinar on gender and community health workers, and appeared to be particularly problematic in contexts affected by crisis, for example rural Democratic Republic of Congo.[13] However, workforce planning and recruitment in crisis-affected settings is typically 'blind' to marginalised groups and fails to acknowledge and react to the distinct pressures faced by different groups.[14]

Lessons for promoting the inclusion of marginalised groups and genders

Health needs

In the past 15 years the provision of healthcare services during crises has been guided by the formation of 'basic packages' of services that are considered to be the most important for protecting health.[15] However such packages accord little explicit priority to the needs of marginalised groups. For example, the specific health needs of trans and other marginalised genders do not feature in the text of those basic packages, while women's health tends to be reduced to issues of reproduction: maternal and reproductive health, and services relating to sexual violence.[16] Thus basic packages of healthcare services in crisis-affected settings may actually reinforce the social relations that undermine equity in the health system.

Improved data collection in crisis-affected settings would help to distinguish between the impacts of basic healthcare packages for different marginalised groups. There is a need for consensus on the best indicators to use for this purpose, as well as greater support for disaggregated quantitative and qualitative data during and following crises.[17] Such data would enable better targeting of health system resources and would reveal how access to, and progress through, health systems in crisis-affected settings are determined by social relationships and how the health system can be altered to encourage inclusivity. Participatory research also has much to offer in contexts affected by crisis; providing opportunities to understand and shape the ways in which social norms affect vulnerability to ill-health and ability to access care. In South Sudan, participatory approaches involved training of community facilitators focussed on 'community dialogue' between older and younger women and men, comparing social and gender norms and practices between present and past, sharing knowledge on maternal health and discussing what needs to be changed for maternal health to improve.[18]

Representation and policy-making processes

Crises can lead to windows of opportunity for equitable policy reforms **(see accompanying brief on universal health coverage)**. This includes opportunities to remove user fees and retrain and expand the health workforce, but also to 'mainstream' social analyses that will ensure healthcare services benefit marginalised groups.[16] For example, detailed analyses of existing and planned policies, and focus on indicators that promote equity, can be used to ensure that their effects are equitable.

Woman at clinic in Cambodia. Better physical accessibility and greater awareness of disability by hospital staff have improved the inclusion of people with impairments. Photo courtesy of CARITAS Takeo Eye Hospital **(http://bit.ly/2sl4GUT)**

Policy-making at all administrative levels must incorporate the voices of marginalised groups. This means increasing representation for such groups within national ministries but also in the district- and local-decision-making bodies that gain influence during decentralisation reforms.[16] Health systems depend on women as providers of healthcare within households, health centres and hospitals, yet women rarely lead within the systems they contribute so much to.[19] Alongside efforts to increase representation, ministries can introduce focal points and training to coordinate and raise awareness of the needs of different social groups. In Timor-Leste and Cambodia for example a focal point for gender was established in the Ministry of Health in each country and staff received training on gender analysis and a focal point for gender was established in the Ministry of Health.[14,17]

The healthcare workforce

Workforce policies need to encourage marginalised groups to enter, remain and progress in different cadres of the health system,[20] yet there is generally a lack of evidence on appropriate policies.[21] One option is to provide support for marginalised groups to train and work in positions where they are under-represented in the health system and to involve them in policy planning and assessments.[14] Health systems mirror their context, reflecting social inequalities throughout the delivery and provision of healthcare services.[16] The health sector can also contribute to and champion social change, and partnership with other sectors (such as education, social welfare) in an inter-sectoral campaign has strong potential to promote inclusivity.

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A provider at a government-run medical facility in Aden, Yemen, examines Somali refugees that recently fled across the Aden Sea.

ReBUILD Consortium

The ReBUILD Consortium is an international research partnership working on health systems strengthening in settings affected by conflict or crisis.

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