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Lessons for health programme delivery in fragile and conflict-affected states

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Question

What are the lessons learned from delivery of health programmes in a conflict sensitive way? Please cover what worked well in achieving positive health outcomes in difficult fragile and conflict-affected state (FCAS) environment without exacerbating drivers of conflict?

Contents

1. Summary

UNICEF (2016) recommend communications is key for conflict-sensitivity both within health programmes and more widely. Mechanisms to facilitate community discussions are important and communications from the government or operating organisations must be clear. Government and operating agencies must be trained in conflict-sensitivity. Health facility staff should be representative of the population and trained in non-discriminatory practices.

Recommendations on conflict sensitivity and health programming identified in this review include:

- Coordination between governments and implementing agencies
- Training for healthcare staff in conflict sensitivity
- Health and hygiene promotion for refugees
- Social cohesion activities for refugees and host communities involving children

Lessons for achieving health outcomes in fragile and conflict affected states include:

- Political commitment and government ownership
- Participatory decision-making
- Evidence-based programming and refinement
- Reliable and sustained funding
- Strengthening of community structures that provide support in health

Programming experience in fragile and conflict-affected states:

- **Capacity building**. Consider the long-term, focus on the health system as it is rather than how the international community think it should be. Pay attention to connections between health system components, and include procurement training.
- **Contracting out**. There are arguments for and against contracting out which should be weighed up depending on context. Contracting of services can allow more focus on measurable results, increase managerial autonomy, draw on private or non-governmental organisation (NGO) sector expertise, and allow for rapid expansion of services. Problems with contracting are that competition may not exist, monitoring capacity may be weak, management costs may be high and further fragmentation of the health system may be undesirable.
- **Health pool funding**. Aim for quick roll out but ensure plans and packages are technically sound. Allocate resources proportionate to need. Adhere to decisions balancing sustainability and access. Provide long-term technical assistance.
- **Labour markets**. Staff working in difficult contexts should be financially rewarded as well as provided with housing and having their security ensured. Community and external support for these workers should be strengthened. Human resource management systems are needed to coordinate effectively across a region.
- **Different providers**. A variety of providers can be challenging to organise but improves resilience. Coordination of multiple actors is very important.
- **Gender**. Programming must ensure it will be servicing all populations equally. Gender equity must come into workforce considerations.

2. Best practice on conflict-sensitivity

UNICEF recommendations

UNICEF (2016) recommend programming entry points for supporting social cohesion in health, nutrition, and HIV programming at different levels.

Policy and state-level:

- Communication mechanisms for social groups to voice their needs and expectations.
- Advocacy to encourage government to support more equitable health services.
- Supporting governments with communications strategies showing their ambition to improve access to health.
- Advising and supporting governments with policy for non-discrimination practices related to HIV.

Community-level:

- Ensuring full participation of diverse groups in consultations and programming design.
- Establishing structures for managing projects that include diverse groups.
- Highlighting the 'child as the connector' to bring divided groups together.
- Ensure that staff of public health facilities are representative of the population.

Individual-level:

- Training service providers to ensure non-discriminatory practice.
- Ensuring equitable and inclusive emergency relief.
- Communicate that health service delivery is only possible after the cessation of hostilities.
- Reduce stigmatisation of HIV and AIDS.

The report also makes programming recommendations for conflict sensitivity in WASH.

Policy- and state-level:

- Strengthen systems and structures for equity-oriented and evidence-based WASH services at, and between, all levels of society.
- Ensure the interests of vulnerable groups are at the centre of resource management.
- Support grassroots organisations to voice their needs.
- Strengthen mechanisms for ongoing consultation between government and local-level.
- Enhance institutional understanding of local resource pressures, which result in water-related conflicts and enhancing structures for resolving them.

Community-level:

- Implement joint collaborative water development projects that facilitate safe and constructive contact between divided groups.
- Create incentives for joint action and provide platforms for collaboration.

- Understand and leverage indigenous systems for managing water.
- Strengthen the role of women in water management.

Individual-level:

- Enhance individual understanding of WASH as a common need.
- Enhance the peacebuilding competencies of individuals engaged in water management activities.

3. Experience from country case studies

Lebanon

An assessment report for conflict sensitivity in the primary health sector in Lebanon identifies issues in healthcare competition driving host-refugee tensions (Integrity Research Consultancy, 2014). Hosts blame refugees for pressure on services. Targeting is a problem, with refugees receiving more assistance with healthcare subsidies than hosts. Prioritisation of refugees with emergency needs has been questioned. There are misconceptions about the level of coverage provided for refugees. There are accusations that refugees re-sell their aid. Additionally, hospitals are accused of profiteering.

Lack of coordination between government bodies, UN agencies and INGOs had resulted in both over and under provision for selected medicines creating tension when certain medicines were "earmarked" for Syrian patients. Healthcare staff and hosts communities complain about the lack of hygiene among refugees. Often, host communities end up avoiding centres that serve refugees. Lebanese patients are not willing to wait behind refugees. Segregation avoids immediate tensions but is detrimental to long-term social cohesion.

An International Alert lesson sharing seminar on conflict-sensitivity and healthcare in Lebanon[1] agrees with the findings of the assessment report. Further coping strategies participants described was deferral of healthcare for patients and prioritising the most important procedures.

The institutional capacity of primary healthcare centres is limited (Integrity Research Consultancy, 2014). Staff did not have understanding of conflict dynamics. Adopting conflict-sensitivity was not seen as a priority. Conflict-sensitivity was thought to take up extra resources rather than simple changes in work practices.

Practical conflict-sensitivity mechanisms present were Refugee Outreach Volunteers for healthcare and hygiene promotion and public information campaigns to raise awareness of healthcare subsidies and support for Syrian refugees.

Space for testing conflict-sensitive approaches is further recommended by Integrity Research for greater coherence in policy formation.

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[1] https://www.international-alert.org/news/conflict-sensitivity-and-healthcare

The lesson sharing seminar report[2] suggests equalising out-of-pocket expenses for Lebanese and Syrian patients, hiring additional doctors to reduce the waiting times for Lebanese patients, and 'task shifting' between primary healthcare staff. Project capacity building activities work best when training is aimed at combining change at the individual level, change at the relationship level, and social change. Mixing Syrians and Lebanese in awareness raising sessions was found to be more successful when participants shared a common socio-economic background. Activities for children were also a good way to bring people together. International Alert experts recommended that for success, conflict-sensitivity concepts must be integrated from the beginning.

Afghanistan

Impressive health outcomes in Afghanistan from a partnership between the Ministry of Public Health (MOPH) and donors include improvements in health indicators, expanded access to services, and an increased range of services. Outcomes are reported to be attributed to (Dalil et al., 2012):

- Ownership for the MOPH.
- Coordination and collaboration of donors initiated by MOPH.
- Participatory decision-making.
- Basing programmes on evidence and performance monitoring.
- Reliable aid flows.
- A group of individuals with the right experience and expertise being deployed at the right time.

A case study of a tuberculosis programme within primary care services in Afghanistan described successful outcomes (Seddiq et al., 2014). Factors for success were high political commitment and strong leadership. The authors recommend phased withdrawal of international support and increase in resources to the national programme for long-term effectiveness.

Sierra Leone

A *Secure Livelihoods* report on Sierra Leone (Denney et al., 2015) shares experience on health sector capacity after Ebola. Capacity building was "thought about and operationalised in a limited manner" (p.iv). There was more focus on building skills at the individual and organisational level rather than the systems level where politics, power and incentives are important. Other oversights reported include:

- Lack of realisation of the complexity of basic interventions.
- Overlooking the plurality of health providers that people use.
- Focusing on discrete health system units rather than the connections between them.
- Missing the importance of the human and social dimensions of the health system.

Recommendations for capacity building include:

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[2] https://www.international-alert.org/news/conflict-sensitivity-and-healthcare

- Beware that the emergency mindset can distort programming. Consider long-term as well as medium-term.
- People must trust the health system, and this must be considered in capacity building approaches.
- Capacity building should focus on the health system as it is used rather than how the international community think it ought to be used. This means accepting providers other than the government.
- Pay attention to the connections between health system components including feedback loops and relationships between both individuals and organisations.

Reporting on how health workers managed during the Ebola epidemic shares how they feel sustained by religion, enjoy a sense of serving country and community, and receive peer and family support (Raven et al., 2018). External support included confidence training, safety equipment, a social media platform to share challenges, workshops on how to deal with the stigma, and financial compensation.

South Sudan

Assessment of post-conflict recovery in southern Sudan identifies fragmentation of the health sector directly after the conflict (Cometto et al., 2010). Coverage of services was low, health outcomes were poor and government capacity was limited. Health policy was then shaped by the combination of actors and processes. The World Bank and the World Health Organisation became the primary drivers. Lessons learned from the case study include:

- The need for sustained investment in assessment and planning.
- Early focus on building capacity for procurement.
- Funding instruments that can disburse funds rapidly.
- Streamlining government structures and procedures and adapting them to local context.

Research on providing mental health support in South Sudan describes challenges and recommends a focus on community-based support to complement government and NGO services (Goldsmith & Cockcroft-McKay, 2019). The need to coordinate different actors is highlighted. It is difficult to integrate mental health into primary health due to lack of funds. Staff capacity is limited and training weak leading to mistakes such as over-prescription of medication. Where treatment plans are suitable, inconsistent supply is a problem. Community-based care is, therefore, particularly important. Existing community structures should be strengthened. Community initiatives encourage ownership and empowerment where service-delivery does not. Traditional healers may also play a key role. NGOs should take the time to learn about local practices and beliefs.

Jordan

An evaluation of a Minimum Initial Services Package[3] (MISP) for Syrian refugees in Jordan provides lessons for future programming (Krause et al., 2015). Implementation was supported by pre-existing health infrastructure, MISP trainings, dedicated leadership, and adequate funding.

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[3] https://www.unhcr.org/4e8d6b3b14.pdf

Problems in uptake were caused by lack of national protocol on clinical management for rape survivors, lack of information about the benefits for potential users, and perceived cultural repercussions.

Mali

Research to improve health services for conflict-affected populations in Mali advised a focus on strengthening and supporting community healthcare structures (Debarre, 2019). The researcher also recommends that the humanitarian space be preserved. There needs to be more emphasis on noncommunicable diseases and mental health. Improved coordination is needed between donor agencies, development actors and global health actors. There is a need for humanitarian actors to have more accountability to the populations they are serving.

Sri Lanka

In Sri Lanka, following forced displacement as a result of flooding, there was host community representation on camp committee meetings and social events with neighbouring residents as part of health promotion and psycho-social activities (Zicherman, 2011). This helps to build relationships and release tension between refugees and locals.

Uganda

A study used applied social network analysis to look at inter-organisation infrastructure providing health services in the reconstruction phase after the conflict in North Uganda (Ssengooba et al., 2017). Eighty-seven organisations were identified in the analysis. The findings showed that organisation networks mostly focus on HIV and least on workforce strengthening. This approach was useful for gaining knowledge for building organisational networks in more equitable ways.

4. Process guidance

Contracting out

A British Medical Journal article (Palmer et al., 2016) looks at the lessons from Afghanistan where many health services were contracted out to both national and international NGOs. In the context, NGOs were most experienced in the difficulties of delivering the services. They also tend to be more agile. The authors outline the arguments for contracting out as allowing more focus on measurable results, increasing managerial autonomy, drawing on private sector expertise, increasing efficiency through competition, and allowing for rapid expansion of services. It also frees up the government to focus on other tasks. The arguments against contracting out are that competition may not exist, contracts may be difficult to outline and monitor, management costs may be high, it may contribute to fragmentation of the health system, and government stewardship capacity may be weak.

Huges et al. (2012) note the importance of a strategy for eventual transition to government-led health system when contracting out.

Health pool funding

Liberia had positive experiences with multi-donor mechanisms and government systems for health system reconstruction in early recovery (Hughes et al., 2012). Recommendations include:

- Aim for plans and packages to be able to be rolled out quickly but be technically sound enough to be expanded as the country develops.
- Plans and packages should be costed to allocate resources proportionate to need.
- Be clear about decisions to balance investment in system sustainability and service accessibility and adhere to it.
- Long-term, embedded technical assistance is important for increasing institutional capacity, accountability, and sustainability.
- Flexible funding should be used where it can maximise benefits and project funding should be channelled where needed.

See Banke-Thomas et al. (2019) for an exploration of how to embed value-for-money into a health pooled fund in South Sudan.

Health labour

Health labour markets in fragile contexts are more complex. Policies must avoid draining staff from hard-to-serve areas (Witter & Martineau, 2019). Incentives for staff to work in these areas should be more than short-term financial incentives and should involve meaningful recognition of their achievements, measures to ensure their security, provision of decent housing, and measures to establish trust. Planning should focus on reinforcing resilience and investments should consider long-term implications.

Experience from Northern Uganda on health workers recommends human resource management systems be in place across all major employers and sectors (Ayiasi et al., 2017). Managers should share observations of attrition trends if possible, to support understanding of labour market dynamics. Ideally, during conflict, a harmonised platform for staff recruitment for governments and agencies should be established for healthy competition and labour market stability. Formal recruitment processes that may have collapsed during the conflict need to be rebuilt as soon as possible.

Different providers

The variety of different providers in conflict-affected countries can be challenging to regulate but also improves resilience of a health system (Witter & Hunter, 2017). Governments have capacity constraints in financing and managing the plurality of providers and authors suggest adopting an agile approach to mitigate weaknesses of each sub-sector. More resources should be directed to frontline providers with stronger supervision. Access may need to be negotiated for specific groups to use health facilities run by different organisers (domestic or international military, or other ministries). NGOs should be supervised to transfer capacity to local partners through a structured plan. Community healthworkers can help to connect informal providers to training and supervision. Strong dialogue between provider groups must be maintained and monitored for unequal distortions.

The key policy recommendation from the ReBUILD consortium (producing health systems research in FCAS) is the need to coordinate multiple actors (Martineau et al., 2017). They also highlight power imbalances which must be addressed for inclusive, sustainable, and responsive nationally and locally owned institutions to provide equitable and effective health services.

Gender

Equity must be considered when rebuilding health systems after crisis (Witter, Hunter & Theobald, 2017). Approaches and strategies must involve focus on access for marginalised genders, disabilities, ages, ethnicities, and classes. Policy and action must also be in place to improve gender equity in the health workforce (Witter & Martineau, 2019). The opportunity for gender equity in post-conflict reconstruction must not be overlooked (Percival et al., 2014). Focus should be on gender equity in the workforce, gender equitable financing mechanisms, and leadership for gender equity during reforms.

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