Health systems in situations of fragility

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Overview

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2. Fragility – what does it mean?
3. Features of fragile & conflict affected health systems
4. Implications for different building blocks
5. Fostering resilience
6. Focus of research to date
7. Outstanding research questions
Background

• **ReBUILD programme**, 2011 onwards
• **Research to identify and foster resilience** through health systems analysis of UNWRA provision for Palestinian refugees from Syria, 2016-18
• Consultation for Global Fund on RSSH in COEs, 2016
• **NIHR Research Unit on Health in Fragility at QMU Edinburgh**, 2017 onwards
Fragility – what is it?

No agreed definition but common consensus around gaps in:

- **capacity** and **willingness** to provide basic services to population (especially vulnerable groups)
- **legitimacy** and
- **Authority/control of violence** (OECD, DFID, World Bank, Newbrander 2011)

- Can apply at state level or below (mosaics)
- Some areas may perform better on some dimensions (e.g. capacity) but less well on others (e.g. legitimacy)
- Dynamic - though states can get stuck for prolonged periods: 108/131 countries did not change categories over 2000-2010 (Tikuisis et al. 2015)
- The most poorly performing population groups and countries are those impacted by conflict, natural disasters or disease outbreaks (World Health Organization 2016); often long and non-linear transitions out of conflict; exacerbated by low income levels
- Fragility may also **predict** conflict – e.g. ‘brittle’ category (high capacity but low legitimacy and authority) included Arab Spring countries and Syria
Figure 1: Intersecting gaps of statehood according to Call

- **CAPACITY GAP: Weak States**
  - Bangladesh
  - Malawi

- **LEGITIMACY GAP: Repressive Autocracies**
  - Zimbabwe
  - Equat. Guinea
  - North Korea

- **SECURITY GAP: War-torn States**
  - Ivory Coast
  - Burundi
  - Haiti, Uganda
  - East Timor

- **Other States**
  - Afghanistan, Sudan, Somalia
  - DRC, Iraq
  - Turkmenistan
  - Colombia, Bosnia, Tajikistan, Guatemala

Source: Call (2010).
What does that mean for the health system?

In fragile states, the health system building blocks are by definition weak and incomplete (Eldon, Waddington, & Hadi 2008). Characteristics include (Newbrander, Waldman, & Shepherd-Banigan 2011):

- inability to provide health services to a large proportion of the population outside urban areas;
- ineffective or non-existent referral systems for the critically ill;
- a lack of infrastructure (including facilities, human resources, equipment and supplies, and medicines) for delivering health services—what did exist has been destroyed or severely compromised due to war and/or neglect;
- non-existent or inadequate capacity-building mechanisms and systems, such as national clinical training programmes, to address the dearth of clinical and management capacity;
- insufficient coordination, oversight and monitoring of health services by the emerging government, which may not have the capacity to manage;
- lack of equity in who receives the available health services: few public health services exist for the poor and in rural areas;
- lack of policy mechanisms for developing, establishing and implementing national health policies;
- non-operational health information systems for planning, management and disease surveillance; and
- inadequate management capacity and systems (such as budgeting, accounting and human resource management systems) for controlling resources.

But consequently, can also provide space for experimentation and innovation...
Why focus on fragile and conflict affected states?

Need
• Fragile states are home to 1/6 of the world’s population, but 1/3 of those live on < US$ 1/day
• More than 1/3 of maternal deaths worldwide occur in a fragile state
• Half of the children who die before age five live in a fragile state
• In 2014: 40 armed conflicts in 27 locations worldwide – highest reported since 1999
• These trends have intensified in recent years.
  – More people displaced (60 million) than at any time since World War II
  – Growing direct deaths from conflict, but even more indirect deaths from systems breakdown
• Essential to SDGs

Externalities
• Seen also as reservoirs of disease, conflict and terrorism

Underinvestment
• However, fragile states receive around 50% less aid than predicted
• Also limited HSR attention
IMPLICATIONS FOR DIFFERENT BUILDING BLOCKS

HEALTH FINANCING
Health financing in FCAS literature review 
(Witter 2012)

• Focus of most existing literature was on immediate post-conflict period and on role of donors

• Insufficient attention to changing mix of financing mechanisms over time, how these affect equity and access, and other areas such as resource allocation, regulation, public financial management, payment systems and incentives at facility and health worker levels

• Research methods reflect the difficulty of collecting original data in many of these settings and could be strengthened, e.g. by longitudinal methods
Health financing & state-building

The post-crisis moment offers risks and opportunities:
• Risks include capture of resources by privileged elites or increased opportunities for patronage and nepotism
• Opportunities include a new settlement in which governing actors revive the social contract through equitable financing, distribution of resources (such as infrastructure and staff) and services.

Health financing design in particular can communicate political and social values, e.g.:
• Social solidarity (cross-subsidies, and pooling)
• Inclusion (targeting poorer areas)
• Equity (reducing financial barriers)
• Reconciliation (resources allocated to opposition areas)
• Human rights (establishing constitutional rights to health care)
• Participation (civil society involvement)
• Confidence in public stewardship (e.g. donor resources channelled through public systems)

Some research on this (e.g. Kruk et al 2010), but underdeveloped area still
External finance

• Fragile states typically have low domestic resource mobilisation: on average, only 14% of the GDP of fragile states (OECD, 2014)

• In countries emerging from protracted crises, external support may need to increase over time as service provision expands.
  − E.g. governments in Cambodia and Rwanda have made impressive progress in expanding coverage of healthcare in the aftermath of conflict, however both have relied heavily on international funding

• The achievement of sustainable and equitable financing systems for the health sector requires realistic, long-term strategies
User fees

- Even more limited capacity than usual to mobilise funds through this channel post-conflict and yet also a very hard environment to assure facility funding (and so combat informal payments)
- Guidelines against user fees during crises, but after may proliferate
- Changing household access patterns typically. E.g. in Uganda and Cambodia there was a shift in source of healthcare, from formal private providers to public and informal private providers, particularly among the poorest.
- Reforms that target reducing OOP for the poor have some (limited) effectiveness in Cambodia and Sierra Leone
- Some success with exemption mechanisms such as health equity funds in Cambodia, managed by NGOs, but which now face challenge of integration into government systems
- Also targeted insurance schemes in humanitarian settings, e.g. for IDPs in Sudan
- Important role for civil society to monitor equitable financing and access
Performance-based financing

Theory led literature reviews (Bertone et al. 2018) - 140 documents in total, covering 23 PBF schemes.

- We find that PBF has been more common in FCAS contexts, which were also more commonly early adopters.
- Often multiple schemes – e.g. DRC (7) and Burundi (6) over past ten years
- Very little explanation of the rationale for its adoption, in particular in relation to the contextual features, is given in programme documents. However, there are a number of factors which could explain this, including:
  - the greater role of external actors and donors
  - greater openness to institutional reform
  - lower levels of trust within the public system and between government and donors
  - flexibility (or absence) of existing institutions
  - entrenched interests and power relations
  All of which favour more contractual approaches

- Interesting patterns of policy diffusion

These suggest that rather than emerging despite fragility, conditions of fragility may favour the rapid emergence of PBF

Also highlights the need for greater clarity on how PBF interacts with the contexts, and in particular with FCAS features, both ex ante (at the stage of adoption and design/adaption) and ex post (during the implementation and the assessment of health system effects).

Outstanding key question: the extent to which PBF is reinforcing – or not – fragile states
Adaptation of PBF in humanitarian settings (Bertone et al. 2018)
HEALTH WORKFORCE
Production & training

Post-crisis, health worker supply is usually distorted and inadequate. Foreign staff can fill severe gaps in the local workforce, but distortion of health worker supply and salaries by the aid industry is a risk.

Training is important but can be mishandled
- e.g. over-production of poorly trained staff with risks for future sector
- alternatively, investment in IST which brings in resources but is not effective on performance
- Possible however to train new cadres with strong PHC orientation, e.g. in Timor Leste

Introduction of new cadres as a response to post conflict staffing may generate problems in the long-run (e.g. introduction of Primary Care Nurses without clear career pathways in Zimbabwe)

The nature of the longer term political settlement will of course determine the extent of confidence in the government and willingness to engage in public sector employment.

Impact of conflict and crisis on staff

- Staff have often been **targeted during the conflict**, leaving areas lacking staff, some carrying out roles above their station, and traumatised.
  - Where staff have been targets during conflict and crises, **psychosocial support** is also needed
- Some positive aspects can be built on – staff developed **coping strategies and resilience** which allowed them to survive, both personal and community-based.
  - These should be recognised and rewarded
Windows: opening and closing

May be a ‘window of opportunity’ for restructuring HRH post-conflict, but not necessarily found in the immediate post-conflict period

- In ReBUILD countries, fundamental reforms came later, when political mandate, external support and capacity were combined
- However, analysis of wider tracer reforms across range of LMICs highlights the role of crises in propelling many of these

Path dependency: importance of key decisions in post-conflict period

- Cambodia: focus on increasing numbers took long time, followed by a decade of management reforms. Now starting to regaining control from NGOs and external bodies over policy and incentive schemes
- Depending on the degree of destruction and loss of staff, the reconstruction of the HRH can take decades
Incentive packages

Fragmentation of incentive structures & complex remuneration

– Linked to multiple actors
– Piecemeal, poorly funded/implemented, no feedback loops
– Aspects needing organisational change receive less priority than financial incentives (easier to finance)
– Impacts on accountability and staff effort?

Need coordinated and balanced incentive package

– Prioritising hard-to-reach areas
– Consultation/communication are key – low-hanging fruit
– Reinforcing supervision
– Improving working conditions
– Gender sensitive
Rural health workers in FCAS face particular challenges:

- Poor working conditions, emotional and financial costs of separation from families, limited access to training, longer working hours (due to staff shortages) and the inability to earn from other sources make working in rural areas less attractive.
- Moreover, rules on rotation which should protect staff from being left too long in rural areas are not reported to be respected.
- Incentives for rural areas limited political focus – especially ineffectual?
- Insecurity

During economic crisis, rural areas can have advantages (e.g. Zimbabwe – lower costs, able to subsist etc.)

To work in remote areas workers need:

- recognition of role and achievements in challenging circumstances
- practical measures to improve their security
- provision of decent housing, working conditions, training and pay
- Ensuring they are prioritised for training and promotion

GOVERNANCE AND WIDER HEALTH SYSTEMS TOPICS
Managing the health market

In many settings, mission-based, other non-governmental organisations and the private for-profit sector play key roles in healthcare provision during and after crises.

Governments often face severe capacity constraints in relation to financing and managing different providers. Should adopt an agile approach to using the relative strengths of each sub-sector and mitigating their weaknesses. For example:

- Directing more resources to the frontline providers in the public system, coupled with stronger supervision.
- Supervising international NGOs to ensure capacity transfer to local partners using a structured transition plan that includes managers at all levels of the health system.
- Ensuring a level playing field for mission-based and other NGO providers in terms of inputs such as staffing, but also in relation to national standards and performance against national goals (also for private for-profit facilities, where feasible).
- Negotiating access for specific groups to use health facilities run by domestic or international military forces, or by other ministries.
- Using community health workers to connect informal providers to training and supervision systems.
Service packages

In conflict-affected settings, emergency packages typically focus on primary healthcare interventions relating to MHCH, immunisation, nutrition, mental health services and the diagnosis and treatment for some communicable and non-communicable diseases.

- Services for trauma and for sexual and gender-based violence are important in conflict-affected settings.

Those packages can then provide a basis for expansion of coverage to include other cost-effective, equitable and financially protective interventions.

Providers need to be adequately trained, resourced and incentivised to implement the chosen services, otherwise the package may have little resemblance to services actually provided.

Also offered in the right places – e.g. in urban slum settings, if populations have moved there during crises
Aid effectiveness

Good practices for aid in fragile & post-conflict settings
  – Need for long-term financial commitments and consideration of long-term effects
  – Importance of speed and flexibility (context-sensitivity)
  – Reinforcing government stewardship and capacity (and avoiding bad practices)
  – Alignment and harmonisation
  – Service integration
  – Local level engagement, linking systems and communities
  – Agile M&E (dynamic and data-limited contexts)

ReBUILD study in northern Uganda used social network analysis to assess satisfaction with relationships at sub-national level: was mostly determined by 1) the ability to negotiate own priorities, 2) awareness of expected results, and 3) provision of feedback about performance (Ssengooba et al. 2017)
Resilience

Growing topic area: how (and whether) to define, measure and promote it

Recent study in three contexts, including conflict-affected northern Nigeria: helped to identify threats and positive practices for recovery from shock, across whole system

Some early lessons are emerging about how to boost resilience, including to:

i. Build stocks, not just of ‘hardware’, such as drugs, but also ‘software’ in the form of trust and competencies

ii. Develop devolved capacity

iii. Develop parallel systems to cope with specific blockages
UNWRA case study
Alamedine et al. 2018 (forthcoming)

Challenge: How to ensure healthcare access for a substantial and changing Palestinian refugee population and meet its increasingly complex health needs during the Syria conflict?

Our findings suggest that UNRWA systems have been broadly resilient in maintaining services, despite vulnerabilities. How? In Lebanon and Jordan we found:

Absorption linked to both soft and hard system resources
- Organizational mission and philosophy
- Solidarity and social cohesion between staff and clients
- Effective emergency preparedness
- Logistical responsiveness
- On-going health system reforms (FHT, E-Health etc.)

Resource exhaustion prompts adaptation
- Facilitating access to care through community links and temporary registration
- Expanding the logistics and procurement network to sustain medicine supply
- Expanding and upskilling HR to enhance service delivery capacity

Re-shaping the health system and wider host-country context: transforming UNRWA’s role and service delivery
- Reconfiguring service offer to address rising health care needs (e.g. MHPSS)
- Introducing systems to improve registration processes (e.g. protection department)
- Bolstering advocacy efforts
HEALTH SYSTEMS RESEARCH
Trends in studying fragile health systems

Frequency of included studies by region (n=333)

- Multi-region
- North America
- Europe and Central Asia
- Latin America and Caribbean
- Sub-Saharan Africa
- Middle East and North Africa
- South Asia
- East Asia and Pacific

Frequency of included studies by publication year (n=332) - *Diaconu et al. forthcoming*
# Research priorities

*Woodward et al, 2016*

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<th>Themes</th>
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| **Transition & sustainability** | • Balance and sequence of emergency and systems strengthening  
                                • Sustainability  
                                • Reforming a post-conflict health system |
| **Resilience & fragility** | • Consensus on definition of ‘resilience’  
                                • Creating resilient health systems  
                                • Relationship HSS and fragility |
| **Equity & gender**        | • Equity issues and fragility  
                                • Relationship more inclusive health service delivery and reduction of tension  
                                • Gender perspective and inclusion of marginalised ‘voices’ |
| **Accessibility**          | • Conflict-related factors to healthcare access  
                                • Referral systems and emergency care access |
| **Capacity building**      | • Health system capacity building, particularly health workforce and leadership  
                                • Capacity building of local researchers and information systems |
| **Actors & accountability**| • Roles of various actors in states with weak governance  
                                • Accountability mechanisms for national and local government and international actors |
| **Community**              | • Community involvement and empowerment  
                                • Community readiness to participate in HSS  
                                • Roles of community-based providers |
| **Healthcare delivery**    | • Innovative approaches to service provision and best service delivery models  
                                • Quality of care and impact of quality improvement on HSS |
| **Health workforce**       | • Human resources for health management  
                                • Education and training of health workforce |
| **Health financing**       | • Best finance practices in relation to aid and the political economy of aid  
                                • Results-based financing  
                                • Universal health coverage |
Health systems research capacity

- The ReBUILD experience highlights the importance of raising the profile of health system research.
- There is a huge unmet need to build individual skills and profile, alongside raising the profile of the field within research institutions and ministries.
  - Skills include empathetic, context-embedded approaches to the consent process and data gathering in particular, given sensitive topics addressed and sometimes the need to recollect and process traumatic events.
- It is also important not to neglect skills development relating to research uptake and strategic partnerships, such as communicating with policy-makers and users of research at different levels of the health system.
- Research management is another area with huge needs for institutional development.
- In many contexts, some basic steps can be influential in starting to build a HPSR community and culture of evidence use: for example, setting up networks of interested practitioners and researchers, developing research repositories, sharing experiences, promoting a demand for research.
- Even academic institutions can be poor at sharing insights and skills across teams, so encouraging a learning culture here and in the wider health system is important!
Some resources

NIHR Centre for Health in Fragility: https://www.qmu.ac.uk/research-and-knowledge-exchange/research-centres-institutes-and-groups/institute-for-global-health-and-development/nihr-research-unit-on-health-in-fragility-ruhf/


ReBUILD resources for HRH: https://rebuildconsortium.com/media/1573/hrh-resources-from-rebuild-april-2018.pdf

ReBUILD resources for health financing:


Summary briefs on ReBUILD findings:
https://rebuildconsortium.com/themes/

Report on Global Fund consultation on resilient and sustainable systems for health in challenging operating environments:


RiNGS: Research in gender and ethics: building stronger health systems: http://resyst.lshtm.ac.uk/rings

Evidence on Coordination and Health Systems Strengthening (HSS) in Countries under Stress: a literature review and some reflections on the findings:
Questions for participants

1. What do you see as the outstanding research priorities on health systems in fragile and conflict affected settings?

2. How can we build partnerships & capacity to enlarge the field of HPSR in this area and get evidence into practice?