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Lauren Kristine Sloan

Post Conflict Public Health: A New Framework for Thinking about Health Systems

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Organizations like the UN do a lot of good, but there are certain basic realities they never seem to grasp ...Maybe the most important truth that eludes these organizations is that it's insulting when outsiders come in and tell a traumatized people what it will take for them to heal.
-Leymah Gbowee, Mighty Be Our Powers

MƆNI NƆ DE AKS IN KƆMPIN USAI I KƆMƆT.
Money doesn't ask its fellow money where it comes from.
-Krio Proverb

Introduction

As war recedes into the background of a country emerging from conflict, the basic factors sustaining the health of its population are often destroyed and dismantled, and the institutions in place to regulate medicine and health are weak or non-existent (Fujita et al, 2011; Garrett, 2000; Ghobarah et al, 2004; Hill, 2004; Kruk et al, 2010; Leather et al, 2006). In the negotiation of new power structures, international donors and development agencies find

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and create space for their presence in nation-states (Farmer, 2005; Fuest, 2010; Garrett, 2000; Hill, 2004). Often, the international "community" of a select and familiar group of actors is called upon to achieve transformative objectives in a nation where the state is both the agent and the object of reconstruction (Fuest, 2010, p. 5). Given the decades-long work of many members of this "community" and arising from their perpetual fragmentation in goals, objectives, and services delivered, standardized models of post-conflict health "kits" have been created (WHO, 2011).

Unfortunately, such kits do not usually match the underlying conditions creating poor health and instability in differentiated localities, and thus, may not contribute to *positively* transformative health outcomes (Cliffe and Luckham, 2000). This is further complicated by the reality that defining a healthy population depends upon the lens through which one understands and sees health, i.e. is health a state to attain to, a social relationship, or an ability to access care through an easily accessible and functional commodity chain (where these are only a few of the various lenses) (Brodwin, 1996; Farmer, 2005; Farmer, 2006; Tabi et al, 2006). Case studies of Liberia and Sierra Leone are utilized to understand the complexities of rebuilding a health system in a post-conflict environment that is fragmented by multiple political, ethnic, and social identities, particularly when those identities are rooted in historically imbalanced structures of opportunities (Stanley, 2004). It is argued that while the current model of post-conflict health intervention includes strong rhetoric on health system strengthening, it does not fundamentally affect the development of the health system because of misaligned priorities and objectives. Further, instituting policies of health systems

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strengthening require that national governments are accountable to marginalized communities and individuals; vis-à-vis strong local governance systems that receive articulated national budget allocations.

Case Studies: Liberia and Sierra Leone

Impact of Conflict on Public Health

The role of conflict in decimating the health infrastructure and the community ties that contribute to positive psychosocial well-being and health resilience was profound in both Sierra Leone and Liberia (Akinsulare-Smith and Smith, 2012; Berhane-Selassie, 2009; Bah, 2011; Day, 2008; Kruk et al, 2010; HRW, 2003; McFerson, 2012; Senessie et al, 2007). In Liberia,

> …of the 293 public health facilities operating before the war, 242 were deemed nonfunctional at the end of the war due to destruction and looting. Doctors, nurses and other health workers fled the country, leaving 30 physicians to serve a population of 3 million (Kruk et al, 2010, p. 527).

In Sierra Leone,

> The long conflict devastated most of the country and more than 3000 villages and towns were decimated through widespread destruction of homes, schools, health care facilities and other basic services and infrastructure. The ten- year civil war forced the displacement of more than half of the country population, mobilized thousands of child soldiers, and left behind around 7000 amputees, claimed the lives of about 120 000 people, and left thousands of war widows and orphans (WHO CCSSL, 2004, p. 6).
>
> … results show that almost everyone was exposed to conflict. The most frequent incidents included attacks on villages (206, 84%), exposure to cross fire (206, 84%), explosion of mines (69, 28%), aerial bombing (203, 83%), mortar fire (159, 65%), the burning of properties (152, 62%), and destruction of houses (179, 73%). 105 (43%) of the respondents reported that they had been abducted. Of these, half had been abducted more than three times (de Jong et al, 2000).

By the end of the war in Sierra Leone, life expectancy had dropped to 38 years (it was 45 before the civil war) (WHO CCSSL, 2004, p. 8). In Liberia, life expectancy fell from 55 years in 1980 to

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47.7 years in 2000 (WHO CCSL, 2005, p. 7). At the end of the war, it was estimated that less than 10% of the population had access to healthcare in Liberia (WHO CCSL, 2005, p. 9). 50% of the health facilities in rural areas of Sierra Leone were destroyed during the war (WHO CCSSL, 2004).

Human rights violations were extreme in both instances of conflict. Bah (2011) describes documented cases in Sierra Leone below:

> The TRC (2004) has documented 40,242 counts of violations committed against 14,995 people during the war. The violations include forced displacement, abduction, arbitrary detention, killing, destruction of property, torture, rape, sexual slavery, amputation, cannibalism, and drugging (p. 208).

Among the targeted populations of both civil conflicts, women experienced and were subject to extreme gender-based violence (Allen and Devitt, 2012; Day, 2008; HRW, 2003; McFerson, 2012; WHO CCSL, 2005; WHO CCSSL, 2004). In Sierra Leone, 70-80% of those displaced by conflict were female (Berhane-Selassie, 2009, p.739). In Liberia, two-thirds of women were subject to violence (sexual and non-sexual) during their displacement, and in other surveys, 77.4% of women noted that they had experienced rape with 64.1% of those women reporting that it was gang rape (WHO CCSL, 2005, p. 8). However, some critics of these collection methods put sexually based violence as low as 5% of the overall population (Cohen and Green, 2012). However, it should be noted that women perpetuated conflict and violence as well, with estimates ranging from “10 percent up to 50 percent for the number of women and girls in various armed factions”, a fact that has been purposefully ignored by the international community’s provision of mental health services for war-affected women in Sierra Leone (MacKenzie, 2009, p.245).

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Liberia

In Liberia, the end of conflict in 2003 did not signal the end of humanitarian assistance (immediate relief rather than rebuilding) (Kruk et al, 2010). Rather, the election of President Sirleaf in 2005 began the "post-conflict" period of public health intervention, which continues today (Kruk et al, 2010). President Sirleaf's administration largely followed the model of post-conflict public health construction noted above, however, the National Health Plan (NHP) of 2007 denoted the BPHS and the essential medicines list (Kruk et al, 2010). The Steering Committee behind the development of the NHP was composed of

> …the World Health Organization (WHO), United Nations Children's Fund (UNICEF), European Union (EU), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), World Bank, Ministry of Planning and Economic Affairs, Ministry of Gender and Development, and Ministry of Education (MoHSW, 2007, p. 5).

The NHP lays out a decentralized operational management structure (the County Health and Social Welfare Team (CH&SWT)), where

> County health authorities will manage county health facilities. They will be responsible for financial management and personnel and will be fully accountable to local constituencies, as well as to overseeing public bodies. The Ministry will focus on health legislation and law enforcement; policy formulation, revision and enforcement; resource mobilization and allocation, national and long-term planning; broad health sector programming; monitoring and evaluation; and technical oversight of service delivery, regulation, major research and development initiatives. The Ministry will work collaboratively with a diverse set of public, private and NGO health sector partners to ensure full coverage of health services to the Liberian people (MoHSW, 2007, p. 6).

User fees for healthcare were suspended (but included as a source of funding for the budget), health spending was to reach 15% of the national budget, and the central four components were "1) Basic Package of Health Services; 2) Human Resources for Health; 3) Infrastructure

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Development; and 4) Support Systems" (MoHSW, 2007, p. 7-8). From 2007-2010 the Ministry estimated its contribution to the budget to increase from 10-33% with external development funding contributing coverage of 40% consistently (MoHSW, 2007, p. 9). Additionally, research published in 2010 notes that

> Liberia's efforts to rebuild the health system are further limited by a low health budget, which at 21 United States dollars (US$) per capita is approximately two-thirds of the recommended spending on essential health services. Liberia's health sector is also highly dependent on donor assistance: approximately 80% of the country's health spending was financed by foreign donors in 2007 and 2008 (Kruk et al, p. 528).

Thus, Liberia has not been able to meet its own targets for health care delivery and provision of basic services. However, user fees have systemically been suspended in all governmental and NGO-supported health facilities and 79% of mothers receive prenatal care from a health professional (LDHS, 2007), marking improvements in access to health services. The low numbers of mothers who give birth in the presence of a skilled birth attendant (only 37% in 2007, a small increase from the 1999-2000 survey which showed 36%), may be an indicator that health services are not close-by or *easily* accessible, with major determinants of qualified health-care delivery varying between rural vs. urban as well as education of the mother (LDHS, 2007). Notably, "(o)utside Monrovia, where humanitarian agencies provided some services, most of the population has little or no access to health care" (Kruk et al, 2010, p. 527). These indicators imply that the national health system has not effectively been decentralized, and still remains heavily dependent on external assistance. Indeed, "(m)ost clinics and hospitals in Liberia are

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managed by contracted national and international NGOs with payment based in part on their performance in extending coverage of essential health services and assuring quality" (Kruk et al, 2011, p. 2058). How quality assurance and extension of coverage is monitored is not clear within the available data. In a population preference study conducted in Nimba Country,

> …nearly four-fifths (79.1 percent) of respondents reported being satisfied with their country's current reliance on NGOs for management of public health facilities. However, 59.1 percent believe that the government should be the sole manager of health facilities in 10 years, while 26.4 percent believe that the government and NGOs should both be managing health facilities in 10 years (Kruk et al, 2011, p. 2066).

Much of the funding for public health continues to come in through disease-specific programs that preference the concerns of donors, where for instance, in 2008, "USAID committed US$ 7 million to maternal and child health versus US$ 15.6 million for HIV and malaria" (Kruk et al, 2010, p. 532) while "the prevalence of human immunodeficiency virus (HIV) infection in Liberia was estimated at 1.5% in 2007" (Kruk et al, 2010, p. 527) and maternal mortality was a very high 994 per 100,000 live births, with 39% of under-five children affected by stunting (WHO-CCSL, 2009). These funding priorities specifically play into access, where "(m)ore than half (55.9%) of the respondents could access HIV testing and counselling services at their nearest facility" but only "(o) ne-quarter (26.8%) of the respondents could access basic EmOC" and only "14.5% could access IMCI services" (Kruk et al, 2010, p. 529). However, the US has recently given USD$52 million to a "Rebuilding Basic Health Services (RBHS) program" which "aims to reconstruct and equip more than 100 of the 330 clinics in the country as well provide training to upgrade the skills of nurses and clinic managers" (Kruk et al, 2011, p. 2058).

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These shifts in funding may mark a new direction for transition out of a post-conflict model of assistance and into a transitional, or developmental, stage of assistance.

There are other problematic concerns and misaligned priorities within the national health policy of Liberia. For instance a, "2008 survey found that 40% of the population had self-reported symptoms indicative of major depression and 44% probably had post-traumatic stress disorder" (Kruk et al, 2010, p. 527), while only "12.1% could access mental health services" (Kruk et al, 2010, p. 529). In a recent trip to Liberia, the author was told by various sources that there exists a culturally endemic problem of pregnant abandonment, where men leave women during their pregnancies due to inability to pay for healthcare fees (quoted at USD$100 for anti-malarials and iron supplements) (personal communication). Compounding these issues, "… six years after the end of the war, the electrical grid still operates solely in the capital city, Monrovia. Few roads have been repaired and schools have only recently reopened" (Kruk et al, 2010, p. 527). NGO service provision remains fragmented and coordination among agencies is low, leading to inadequate reporting to the MoHSW (Kruk et al, 2010, p. 528). However, even eight hours outside of the capital in a village only accessible by motorbike, women reported knowledge of NGO's and could state basic information about HIV/AIDS and its transmission (personal communication). Results about population preferences for healthcare are mixed; with some citing distrust of western medicine and delays in care-seeking behavior due to preference for alternative medicine (even given no user fees) (Wilson, 2008), and others stating technical capacity of care as the most important factor for use (Kruk et al, 2011).

Sierra Leone

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The Sierra Leone National Health Policy was drafted immediately following the end of war, and came into effect in October 2002 (later revised in 2009) (SLDHS, 2008). It relates health policy objectives to disease-specific programs, focused on malaria, sexually transmitted infectious disease (including HIV/AIDS), tuberculosis, maternal and reproductive health, acute respiratory infections, childhood immunizable diseases, nutrition related disease, water, food and sanitation born disease, disability, and mental illness (SLDHS, 2008, p. 5-6). However, these do match the top ten causes for outpatient visits as reported in 2002, shown in Table 1, below.

Table 1: Top Ten Causes for Outpatient Visits, 2000-2002

N	Disease	Year		
		2000	2001	2002
1.	Malaria	460881	447826	507130
2.	ARI	252262	261222	297367
3.	Diarrhoea	61009	71645	65067
4.	STI	41713	44992	61072
5.	Dysentery	28260	20525	29172
6.	Malnutrition	15159	11453	22978
7.	Schistosomiasis	317	7963	7960
8.	Onchocerciasis	1224	5561	3389
9.	Tuberculosis	845	1341	1863
10.	Typhoid Fever	180	963	2303

Source: WHO CCSSL, 2004

The National Health Policy was based on a policy of decentralization in which community voice is primed for transparency and accountability (WHO CCSSL, 2004, p. 15). Management of the health system was delineated through three tiers (national, district, community), where 13 District Health Management Teams would be responsible for monitoring, supervising and implementing health strategy, and community health centers would be responsible for

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provision of primary and secondary levels of care (WHO CCSSL, 2004, p. 15-16). By 2007, the Government of Sierra Leone delivered over 50% of health care services in the country, however, user fees for health services (constituting 64% of the health system funding) significantly limited people's ability to access healthcare, and if they did, put their households at great risk of financial insecurity (average income was less than $2 a day) (WHO SL Country Office, 2007, p.1).

In 2010 and within an extremely constrained budget environment, President Koroma announced the provision of free health care to pregnant women, new mothers, and young children in Sierra Leone (Donnelly, 2011; Maxmen, 2013). Koroma himself noted the immediate backlash from the international donor community at this proposal, stating "The entire donor community is saying this couldn't happen. But I am the president, and this has to happen" (Donnelly, 2011, p. 1393). At the time, Sierra Leone was one of the "world's most deadliest places to give birth and be born" (Maxmen, 2013, p. 191). In 2008, only 25% of women delivered in a health care facility, and only 42% of women giving birth with a skilled birth attendant present (SLDHS, 2008, p. xxv-xxvi). Within one month of implementation, the number of children who received care doubled, and cases of treatment of malaria tripled, showing that access to care was severely limited by costs previous to the free healthcare declaration (Donnelly, 2011). That same year (2010) the MOHS published the Core Competencies for Nurses and Midwives Report, creating nationally-recognized levels of certification (Bachelor of Science (Honours), Midwives, Diploma in Nursing, State Enrolled Community Health Nurses and Maternal Child Health Aides) and standards of care expected by each (MOHS, 2010b). Also in

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2010, MOHS developed and published their BPEHS, establishing an essential drugs list as well as further decentralizing the health system into five-tiers (rather than the previous three) (MOHS, 2010a). These institutional developments reflect a deeper understanding and more robust framework of healthcare provision in Sierra Leone, while sending competing messages to donors (a free healthcare announcement and a "status quo" BPEHS). It is notable that the BPEHS did not surface in Sierra Leone until 2010, eight years post-conflict and eight-years after the first National Health Policy. In a perverse way, the declaration of free healthcare exposed the weaknesses of the health system, particularly in the national system of drug procurement, where 26% of all drugs do not arrive at the health facilities they are intended for (Maxmen, 2013, p. 191). Significant issues remain in infrastructure as well:

> "…a lack of electricity, running water, and blood for transfusions frequently makes emergency care unreliable for children with untreated malaria or severe diarrhoea, and for mothers in need of caesarean sections. September, 2012, government bulletins report that only five of 12 district hospitals and about 20% of selected community health centres were prepared to provide emergency obstetric and neonatal care, which still represents an improvement over zero in 2008. Nationwide, 15 hospitals have functional blood banks, up from four in 2008. However, the banks often lack blood (Maxmen, 2013, p. 192).
>
> Only 10% of hospitals and CHCs had regular electricity (national grid and backup generator) and only 60% had any form of water supply. Of the 56 hospitals and CHCs that had water, the source of the water was outdoor plumbing in 31 (55%) cases, indoor plumbing from a borehole or well in 11 (20%) cases, and indoor plumbing from a municipal source in 14 (25%) cases. There was running water and functioning toilets in 44% and 67% of CHCs and hospitals, respectively. In Bonthe, Kailahun, Moyamba, and Pujehun, none of the health facilities visited had means of external communication. Seven health districts had no equipped ambulance. Other types of vehicle used for transporting patients included motorcycles and bicycles. The supply of medicines and other consumables was very poor in most cases. Many of the most important medicines for EmOC were in short supply in CHCs and hospitals: magnesium sulfate, 52%; misoprostol, 6%; anticonvulsants, 7%; and sedatives, 29%. Only 22% of CHCs and

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> hospitals had blood collection, screening, and transfusion materials (Oyerinde et al, 2011, p. 171).

However, it is difficult to state whether the advances in care-seeking and governmental capacity to pinpoint and act upon the weaknesses of the health system would have occurred without the government's commitment to free health care.

Due to the prolific evidence of human rights abuses and trauma from war in Sierra Leone, post-conflict interventions from donors have also been heavily focused on coping and healing, however, they largely focused on individuals roles in the healing process, rather than on social relationships, and thus, most Sierra Leonean women reported them to be unhelpful and ineffective (Berhane-Selassie, 2009; Doucet and Denov, 2012; Fanthorpe, 2007). Approaches found to be effective were given through local healers and were described as including:

> "…advice-giving and directive practice, self-disclosure and references to religion, as well as the importance of forgetting…these local helpers utilized a variety of skill sets, and focused heavily on principles of solidarity and spirituality rather than clinical diagnostics and psychology. The war-affected women, all of whom were survivors of wartime sexual violence, deemed these approaches and techniques as essential to their post-conflict healing and recovery" (Doucet and Denov, 2012, p. 618).

Individuals in one refugee camp framed international aid agencies quite negatively; dwellers stated that they just 'drove back and forth all day long with nothing to show for it' (Berhane-Selassie, 2009, p. 742). Contestable outcomes are also seen in commitment to decentralization. Attempts to avoid partisan politics and desires to avoid restoring power to the APC, particularly in Freetown, hindered donors commitment to decentralized governance as well as to positive health outcomes for the urban population (representing almost 1/5 of the national population)

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living there (Esser, 2012). In fact, international donors refused to fund an-APC elected City Council to create sanitation systems and coordinate the removal of municipal waste, fearing a backlash from the SLPP-run national government (Esser, 2012). Instead, the WHO funneled USD$2.8 million into the central government for sanitation in Freetown; in frustration, the City Council refused to cooperate (Esser, 2012). Essentially,

> By insisting on decentralisation, yet championing national leadership and keeping local politicians at bay, international agencies hampered the provision of services in the capital and, at the same time, stymied possibilities for urban politics to play out in ways that could have amplified the voices of local constituents (Esser, 2012, p. 413-414).

In the authors trip to Sierra Leone in May of 2012, visible and massive piles of trash continue to line the streets of Freetown, regularly burned during the day in relative proximity to school children and homes (personal observation). Additionally, where there exists an electrical grid, electricity is rarely provided and even basic household refrigeration of foods is simply futile (personal observation). The authors interaction with the health care system in Sierra Leone involved calling a physician, who drove up on the side of the street, provided a diagnosis of illness on the sidewalk of Freetown, and prescribed three different types of antibiotics (which proved to have significant side-effects) for a case deemed as “dehydration” (personal observation). Antibiotics were picked up at a local pharmacy for a total cost of USD$6 (personal observation), more than three times the daily wage of a majority of the nation’s population (EC, 2008).

Conclusion/ Alternative Policy Frameworks and Recommendations

Through the case studies of Liberia and Sierra Leone, the post-conflict intervention strategies of the international donor community prove to be institutionally and administratively

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rigorous with little to no significant impacts on systematically combatting the primary causes of mortality in either country (Kruk et al, 2010; LDHS, 2007; Maxmen, 2013; Oyerinde et al, 2011). Additionally, access to health services continues to be limited by lack of infrastructure, communication, and transportation networks, and integration of the health system is out-funded by disease-specific programs (Kruk et al, 2010; LDHS, 2007; Maxmen, 2013; Oyerinde et al, 2011). Thus, as noted previously, while the current model of post-conflict health intervention includes strong rhetoric on health system strengthening, it does not fundamentally affect the development of the health system because of misaligned priorities and objectives (Berhane-Selassie, 2009; Doucet and Denov, 2012; Esser, 2012; Fanthorpe, 2007; Ghobarah et al, 2004; Hill, 2004; Kruk et al, 2010; Lion, 2001; MacKenzie, 2009; Ongechi, 2012).

Taking these key weaknesses into consideration, this research argues for the adoption of a post-conflict framework designed around a model of intervention focused on a health systems strengthening as shown in Figure 4, below.

Figure 4: A Cube Approach to Health Systems Strengthening

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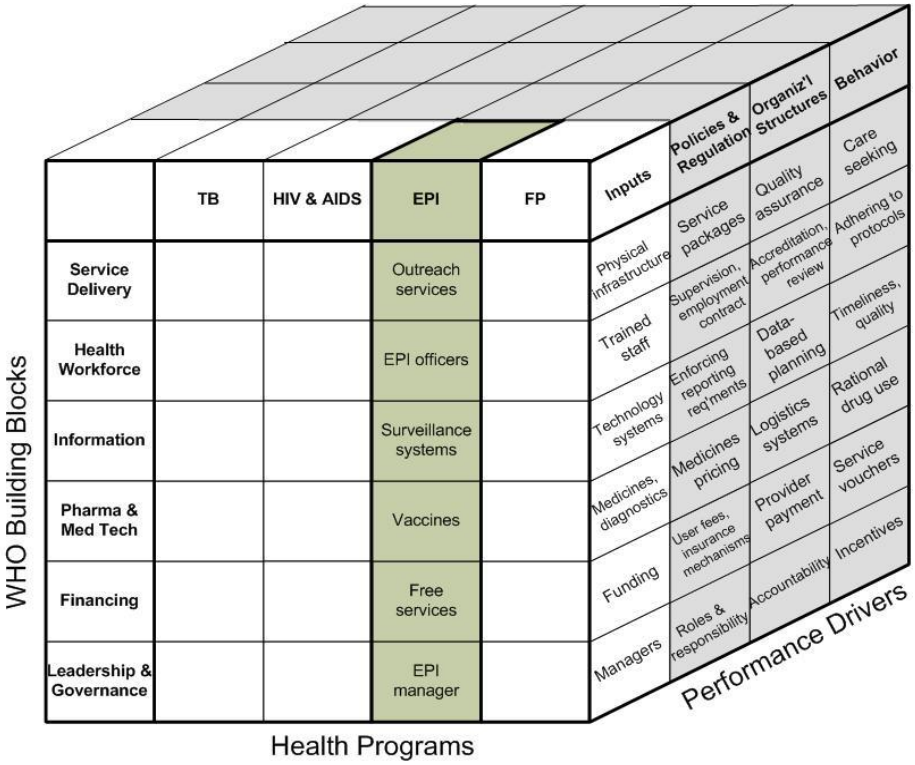

Source: Lion, 2001.

Utilizing this cube-view of the health system developed by the Abt consultancy group, concrete alternative policy frameworks and intervention strategies can be developed. Instituting policies of health systems strengthening require that national governments are internally and externally accountable to marginalized communities and individuals; vis-à-vis strong local governance systems that receive articulated national budget allocations (Ongechi, 2012). Such local allocations must be effectively monitored and evaluated for their reach and access; an area in which local NGO's can assist governments in the reconstruction and development phase (rather than focusing on service delivery themselves). Effectively, "…rather than taking cues from the central government's foreign paymasters, candidates will instead focus on articulating their visions for improving local living conditions through locally

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accountable political action" (Esser, 2012, p. 417). Requiring local governance in health delivery without providing the necessary linkages or supply chains for referrals, medicines, and building upon existing knowledge of local health practitioners (to bring them into the national health system, rather than alienating them and losing potential healthcare providers) is simply an administrative "hand-off", rather than a real, functional, decentralization of health (Azetsop, 2011; Bah, 2011; Esser, 2012; Galea et al, 2010; Ongechi, 2012).

Through another lens, other studies have empirically shown that access to infrastructure and transportation networks increases populations national identity and promote social cohesion (Galea et al, 2010). This suggests that "…interventions aimed at rebuilding social and physical infrastructure in these areas may be an inextricable part of mental health treatment…" (Galea et al, 2010, p. 1750), one of the major negative health outcomes of prolonged war. In countries such as Liberia and Sierra Leone, where rural/urban disparities have contributed to unequal human development and are a root cause of conflict, focus on infrastructure and correcting regional disparities in health and economic outcomes should be a critical focus area of post-conflict health interventions. It is also essential to note that in many ways, healthcare is and has become politicized through notions of health access as a human right, which the author found to pervade public perceptions of the sector in both Sierra Leone and Liberia (personal communication). People expect improvements in their living situations and health and sanitation facilities, particularly after a period of sustained decimation of those needs and facilities. Thus, this research shows that understanding and accounting for behaviors regarding healthcare are essential to creating a framework for effective

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implementation of policy. Incorporating these elements and complexities surrounding the meaning and expectations of health into formulation of the National Health Policies (and at that stage of the intervention model listed in the literature review of this paper) can, as Rushton (2005) states, create an enabling environment for health in two ways: to communicate trust of government in local capacity and for local communities to build trust in central government capacity and accountability, both key in transformative post-conflict peace building and long-term recovery. As of now, the post-conflict public health intervention model falls short, priming cost-effectiveness and donor priorities in service and health provision, while underestimating the critical importance of health-seeking behavior and structural impediments to care. Fundamentally, understanding the multiple dimensions of rebuilding and transforming a health system in a post-conflict setting requires a deep understanding of local realities and political power, which are not adequately addressed in the current model of health intervention.

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