

Egbert Sondorp

Senior Health Advisor, KIT Health, Amsterdam

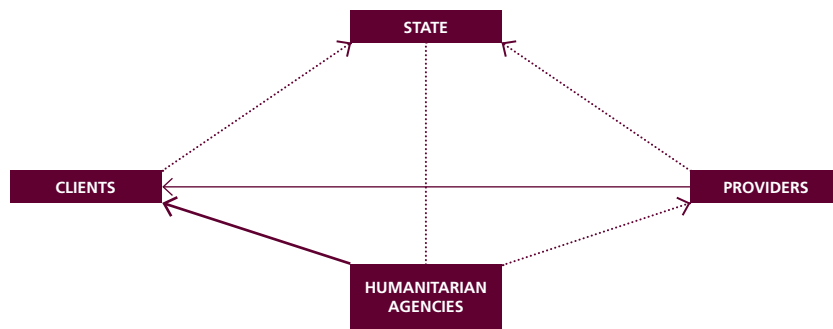
Most armed conflicts over the past decades have been characterised by prolonged civil strife, disproportionately affecting the civil population. Displacement, affected livelihoods, deteriorated health status and economic decline are only some of the consequences. Morbidity and mortality may increase substantially, due to the direct effects of warfare, but often predominantly due to indirect effects as a result of deteriorating determinants of health, including malnutrition, increased epidemic risks, and declines in preventive and curative health services. The government, usually party to the conflict, is often not able or willing to protect its citizens.

Prolonged conflict in often already weak states at the beginning of conflict tends to erode all institutions in the country and will even affect the very fabric of society. Poor institutional capacity typically affects all levels of government, including health authorities at national and subnational levels.

These kinds of conflicts sooner or later will evoke a humanitarian response from the international community, to protect people, with the primary goal of saving lives. Humanitarian health agencies will aim to provide health services by setting up clinics and other services, directly or through pre-existing health facilities. These are often large scale operations that may last for many years. While usually some form of coordination with local health authorities takes place, the humanitarian agencies demand independent action and keep control over their own resources. In many cases, this is the only way to operate to protect citizens and save lives.

These types of 'humanitarian settings' are typically well portrayed in the following diagram. The humanitarian agencies build up direct relations with the population and tend to bypass the state.

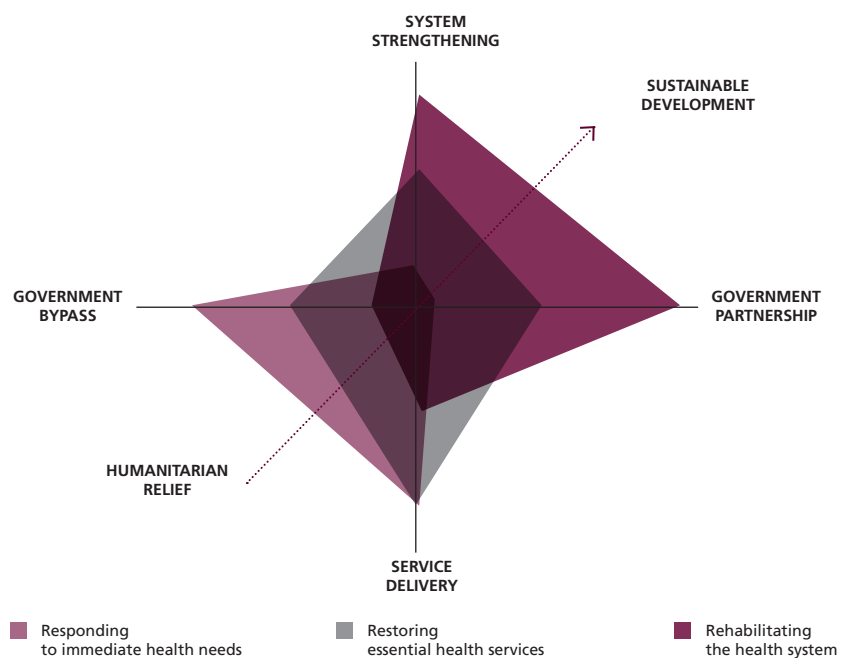
Figure 1. Relations in humanitarian settings



Post-conflict

Sooner or later conflicts will resolve through some form of political settlement. It is rarely an acute moment that leads to a peace treaty, but is rather a lengthy process in which the conflict may subside and re-occur until some lasting stability has been reached. This will also be the moment when the international community will need to change its approach. Humanitarian funding will be reduced, and, more importantly, there is a need to ensure that a viable state emerges able and willing to take care of its citizens. For the health sector this means that health authorities will need to be in charge again, set policy directions, and regulate the health sector. Since capabilities to do so will often be low, this means a lengthy transition process in which the state gradually takes on its role toward sustainable development. In health, there will also be a need to move from a pure focus on health service delivery towards a more comprehensive focus on the whole range of health system building blocks. The next diagram aims to illustrate the transition process.

Figure 2. Transition framework



The transition is never a smooth, linear process. Bouts of insecurity may reoccur, initial political settlements may not hold, and institutional capacities will only gradually improve.

This means that in the early years of recovery, modalities will have to be developed that can contribute to the long term goal of state building, while at the same time provide sufficient levels of health services that both start to improve health, as well as increase trust and legitimacy in a new government.

Low capacities within government, often coupled with low levels of accountability, call for hybrid approaches from the side of the international community and its donors. The aim is to support the emergence of government led policies and strategies. However, the implementation of the chosen strategy may involve NGOs, with an intermediate fund manager channelling the funds from donors to the NGOs outside the government financial systems.

A good example of the latter is the now widespread practice taking place in a range of post-conflict settings where NGOs are contracted to deliver health services on behalf of the government and within the scope of government set general health policies. Contracts, which are usually paid for directly by a donor or its non-state fund manager, may provide the NGOs with more or less autonomy to deliver the services. Local capacity building of health authorities and health providers is usually part of the contract.

This approach tends to lead to a largely supply driven model. A more recent development is to focus on the needs of the people in the communities undergoing health sector recovery. Appropriate involvement of communities, including close-to-community services, is leading to a more demand driven approach and increased accountability from the side of health authorities and providers, which, in turn, is believed to be an essential contributor to state building.

Figure 3. People at the centre of health systems



