PROMOTING HEALTH EQUITY IN CONFLICT-AFFECTED FRAGILE STATES

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February 3, 2007

Prepared for the Health Systems Knowledge Network of the World Health Organisation’s Commission on Social Determinants of Health

By

The Conflict and Health Programme
London School of Hygiene and Tropical Medicine
Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social determinants of health at global, regional and country level.

Acknowledgments

This paper was reviewed by at least one reviewer from within the Health Systems Knowledge Network and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

This work was carried out on behalf of the Health Systems Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The work of this network was funded by a grant from the International Development Research Centre, Ottawa, Canada. The views presented in this paper are those of the authors and do not necessarily represent the decisions, policy or views of IRDC, WHO, Commissioners, the Health Systems Knowledge Network or the reviewers.
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<th>Description</th>
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<tr>
<td>CAP</td>
<td>Consolidated Appeals Process</td>
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<td>CGD</td>
<td>Centre for Global Development</td>
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<td>CHAP</td>
<td>Common Humanitarian Action Plan</td>
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<td>CHF</td>
<td>Community Health Financing</td>
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<td>CHI</td>
<td>Community Health Insurance</td>
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<tr>
<td>CMR</td>
<td>Crude Mortality Rate</td>
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<td>CPIA</td>
<td>Country Political and Institutional Assessment</td>
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<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>DFID</td>
<td>Department for International Development (United Kingdom)</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DRC</td>
<td>Democratic Republic of the Congo</td>
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<td>FFS</td>
<td>Fee-for-service</td>
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<td>FFT</td>
<td>Fee-for-treatment</td>
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<td>HAC</td>
<td>Health Action in Crisis</td>
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<td>IDA</td>
<td>International Development Association</td>
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<td>IDP</td>
<td>Internally Displaced People</td>
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<td>INGO</td>
<td>International Non-Governmental Organization</td>
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<td>IRC</td>
<td>International Rescue Committee</td>
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<td>KN</td>
<td>Knowledge Network</td>
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<td>LICUS</td>
<td>Lower Income Countries Under Stress</td>
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<td>LSHTM</td>
<td>London School of Hygiene and Tropical Medicine</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OECD-DAC</td>
<td>Organisation for Economic Co-operation and Development-Assistance Committee</td>
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<tr>
<td>PRS</td>
<td>Poverty Reduction Strategy</td>
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<td>SDH</td>
<td>Social Determinants of Health</td>
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<td>TRM</td>
<td>Transitional Results Matrix</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNTAC</td>
<td>United Nations Transitional Authority</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Promoting Health Equity in Conflict-affected Fragile States

Executive Summary

This paper was commissioned by the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health in response to their conclusion that a lack of data from conflict-affected fragile states made it difficult to delineate pragmatic ways of creating better social conditions for health for vulnerable populations. The key questions we focused on were as follows:

- What are the main factors that threaten health equity and health care equity in conflict and post-conflict fragile states? Which populations are most vulnerable to worsening inequity under these situations?
- What strategies can reduce the impact of these factors? In particular what steps need to be taken to both build the foundation for future change and address immediate needs?
- What are the roles of different actors at national, regional, and global level in developing and implementing these strategies?

Given the paucity of data to answer these questions, we adopted a broad based approach to data collection including a review of published and grey literature, as well as the use of key informants to provide an experiential perspective. We also conducted an analysis of some pre-existing data sets of health and social determinants of health indicators for fragile states and low income countries.

Although the term equity is often used in a generic way in the fragile state and health literature, there has been no systematic attempt to link the fields of ‘health equity’ and ‘health development in fragile states’. As a result, we have had to build a framework for examining the complex interactions between health equity and the reconstruction of health systems. This framework facilitated an exploration of how conflict – via differential impacts on social stratification, exposures, vulnerabilities, and the consequences of disease – results in worsening health inequities.

This paper is an initial exploration of a complex topic that clearly needs a great deal more research before definitive conclusions can be reached about how to intervene effectively to promote health equity in conflict-affected fragile states. However, we have identified a number of important issues related to the use of the equity concept in conflict-affected settings, including the key drivers of health inequity, as well as some useful strategies for addressing equity in both conflict and post-conflict settings.

Factors that threaten health equity in conflict-affected fragile states

According to DFID, fragile states have governments that cannot or will not deliver core functions to the majority of its people, including the poor. They lack the will and/or the capacity to manage public resources, deliver basic services and protect and support poor and vulnerable groups. The 46 states currently defined as ‘fragile’ are significantly worse off than non fragile states in terms of key health and social determinants of health indicators. This is one of the reasons for the renewed interest in developing effective strategies for working in such environments. In addition, half of these states (23 countries) are conflict-affected. Our analysis revealed that conflict-affected fragile states are significantly worse off in comparison with non conflict-affected fragile states.
Conflict and state fragility are the fundamental drivers of health inequity in conflict-affected fragile states. This is starkly illustrated by the International Rescue Committee’s most recent survey in the Democratic Republic of the Congo, that revealed that mortality rates in conflict-affected areas were two to three times those of non conflict-affected areas. In general, the widespread destruction of institutions and infrastructure, the collapse of the economy and the predatory behaviour of combatants usually leads to a general decline in living standards in war affected countries. This can increase the health equity gap between war-affected countries and other countries of similar socio-economic development. And, once a country has had a conflict, there is a very high chance (44 percent) that it will relapse into conflict again in the early post-conflict stage, which has enormous repercussions for health equity and health outcomes overall.

Paradoxically, equity may be improved within conflict-affected countries because of a levelling down effect – many people (except for the few who profit from the war) may become worse off in comparison to non conflict-affected countries or pre-conflict base lines, and differences between different social strata may become less pronounced. On the other hand, the differential between the most well-off and the least well-off may increase substantially, thus increasing inequity. For instance, in some conflicts the intensity of fighting varies between regions resulting in differential impacts by geographic area. As a result, some subpopulations suffer dramatic declines in health, and there is an increasing equity gap, both within the country, and in comparison with other countries. Lack of robust data makes general conclusions difficult to draw, however.

Conflict also has a profoundly negative impact on health systems leading to reduced capacity for equitable health policy making, planning and service delivery. This problem can be exacerbated if there is inadequate political commitment to addressing inequities that have resulted from a conflict (for example displacement of certain groups, or ethnic or political discrimination). Conflict also results in significant increases in geographical and financial barriers to accessing health care. Geographical access is worsened because of insecurity, which can lead to degradation of health infrastructure, and the flight of health workers to safer areas; it can also make travel to health centres difficult and sometimes dangerous. Together, these factors often leads to coverage deficits, often in rural areas.

Financial access deteriorates by a combination of the impact of conflict on livelihoods and incomes, the collapse of the financial protection function of the health system, and an increasing reliance on user fees in response to inadequate government health budgets and insufficient donor financial commitments (both in terms of amounts as well as in terms of long term commitments). There is little in the peer reviewed literature on the impact of user-fees in the context of conflict-affected fragile states. However, three key drivers of catastrophic payment have been identified for developing countries— the necessity of payment to access health services, low capacity to pay, and the lack of prepayment or health insurance — are all present in conflict-affected fragile states. In-house NGO programmatic assessments suggest that the capacity of user-fees to raise significant amounts of money in complex emergencies is very limited, and the higher the cost of accessing care in complex emergencies, the lower the utilisation.
Displacement is a significant factor driving inequities in health status. For example, some of the highest crude mortality rates (CMRs) in humanitarian emergencies over the last decade have been recorded among internally displaced people (IDPs). IDPs frequently have higher mortality and morbidity than populations not displaced or refugees, whose rights are protected under international law and who have a dedicated UN agency tasked with meeting their needs in stark contrast to IDPs. In some circumstances, refugees and sometimes IDPs can have better access to health services than host populations or stayees (i.e. those who are unable or unwilling to leave their homes), and their health may actually improve as a consequence of their displacement. However, it can be argued that the conditions for such groups are often so bad prior to the intervention of international humanitarian agencies and NGOs that providing a minimum standard of care in accordance with international standards is necessary to address the gross inequity. Some argue that lowering the standard of care available to IDPs and refugees to the level available to host populations would be more equitable and sustainable. Others argue for a levelling up – the ‘islands of privilege’ enjoyed by the refugee populations should be seen as an opportunity to be built upon.

Gender is another significant driver of inequities in health status in conflict-affected environments, in part because women and children are sometimes disproportionately represented in IDP and refugee populations. Gender affects exposure to situations which have an impact on health, and also dictates who has access to health-care services, and how such services are planned and provided. Differential exposure to sexual violence can lead to higher rates of sexually transmitted infections including HIV/AIDS. HIV/AIDS also contributes to gender inequities in health status e.g. the HIV infection rate in adolescent girls post-conflict has been reported to be up to four times that of adolescent boys. On the other hand, men are more likely to suffer and die from violence due to fighting, so there are gender disparities in terms of vulnerability to fighting, being war-wounded and/or killed.

There are numerous examples where ethnicity and/or religious affiliation can become important determinants of health status and affect the accessibility of health care. In general it is the result of specific groups being targeted or discriminated against, such as occurred in southern Sudan or Rwanda.

To address health inequalities in conflict-affected fragile states, it is necessary to address conflict itself, which is the key social determinant of health in these contexts. As Coughlin et al (2006) concluded from their recent mortality survey in the DRC: “Reductions in mortality are closely associated with reductions in violence and, by extension, improvements in security ...” Furthermore, they concluded that their results “provide compelling evidence that improvements in security represent perhaps the most effective means to reduce excess mortality”. Indeed some authors argue that preventing the resumption of conflict is the *sine qua non* of post-conflict interventions, arguing that if you cannot prevent a resumption of violence, most other interventions will be of limited value.

**Suggested strategies for promoting health equity in conflict-affected fragile states**
While it is clear that conflict has an enormous impact on equity, the evidence base on effective strategies for reducing conflict, and promoting equity in conflict-affected fragile states remains very weak. In the health field, more research into equity issues in fragile states and conflict-affected environments is clearly needed. In terms of concrete recommendations, understanding the local context is a prerequisite for developing equitable strategies for health system implementation; the sort of strategies that are feasible depend to a significant degree on how active the conflict is. As a result, while recognising that there is not a linear transition from conflict through to relief and development, we feel that it is useful to differentiate between active-conflict and post-conflict settings. Interventions can also be divided into three general categories: pro-equity policy making; capacity building; and addressing barriers to accessing care.

**Strategies in conflict settings**

In contexts where high levels of conflict persist, security concerns predominate and humanitarian agencies become the only institutions able to provide services. In terms of pro-equity policy making, humanitarian aid should be delivered in accordance with the humanitarian principle of impartiality, providing services for all who need it without regards to race, creed, ethnicity or political affiliation. Aid given should result in a minimum acceptable standard, and should be in line with international best-practice guidelines such as the International Red Cross and Red Crescent’s ‘Code of Conduct’. Policy making should be sensitive to the main context-specific drivers of equity including gender, ethnicity, race, etc. Temporary inequity, such as high levels of morbidity and mortality in IDP populations, should be addressed even if it is done so in ways that may not be sustainable in the longer term.

Humanitarian NGOs have the capacity to provide basic services that the indigenous health system is not capable of delivering. Given the multiplicity of actors, as well as the challenging environment and potential for rapid changes in the context, coordination issues are critical for addressing inequity in humanitarian crises; this is particularly true if geographical coverage issues are to be adequately dealt with. Attempts should be made to maintain existing local capacity if at all possible, e.g. utilising local staff to provide services. Capacity building may be possible, although care needs to be undertaken that it is not done in ways that will undermine equity in the post conflict period.

To address geographical access barriers, services should be provided as close to where people live as possible, although the feasibility of doing so will be significantly influenced by security concerns. Given the severity of the impacts of conflict on livelihoods and incomes, services should be provided free to ensure that there are no formal financial access barriers. Community involvement can assist in designing and implementing strategies to target locally relevant drivers of health inequity.

**Strategies in post-conflict settings**

In post conflict settings, addressing conflict and state fragility are fundamental to addressing health equity in the longer-terms; without security and stability, policies to address equity will have less impact. It should be stressed that policies to address health inequities must be multi-sectoral and include strategies to address fundamental
social determinants of health, especially nutrition, water, sanitation and basic education.

Within the health system, equity should be a core principle of the health policy framework, guiding reconstruction of the health system. Such a health policy framework needs to be developed rapidly in the post conflict period to ensure that the rebuilding of the health system contributes effectively to reducing health inequities; this may require significant external input, at least initially until indigenous policy making capacity is increased and legitimacy issues can be dealt with. In support of this, building in-country capacity in key policy and planning areas should begin as soon as possible after the conflict has ended.

National policy-makers and the donor community should focus on addressing the inequities in service delivery resulting from the conflict, particularly in terms of improving geographical coverage of services. A rapid roll out of a basic package of curative and preventative services should be the primary strategy. Contracting out of services to non-governmental organizations seems to have a useful role to play in this regard, although the evidence base in support of such a strategy needs to be strengthened. Proactive collection of robust data that can be disaggregated by social determinants of health is required to inform pro-equity decision making. Coordination issues must be addressed if pro-equity policy making is to be effectively translated into equitable services. Finally, overcoming geographical access barriers requires that services be delivered close to where people live, which may require security initiatives to ensure that it is safe to travel to services, as well as investments in transport infrastructure.

In general, funding for a basic package will be reliant on substantial external donor support due to economic collapse; user fees should not be relied upon due to the impoverishment of the population. Inequitable global aid flows and aid volatility also need to be addressed; aid flows should better reflect population needs, and donors should commit to 10-15 year time frames. Both reforms would greatly help in effectively addressing equity in the health system.

In conclusion, conflicts are themselves social determinants of health. The important underlying question is not how health programs are implemented but rather how the health sector (together with safe water, food and sanitation) can contribute to identifying and resolving the political, social and even economic drivers of fragility within a given country or region.
1. INTRODUCTION

This paper will focus on how health equity can be promoted by the health sector in conflict and post-conflict states, both directly, and indirectly via impacts on other social determinants of health. It will detail specific health equity issues in such contexts (for example, access to health services for vulnerable populations such as internally displaced people) that can be addressed through health system development.

This paper falls at the intersection of two burgeoning areas of public health research and policy: *health equity* and *health service delivery in fragile states*. Health equity, at the global level, has been the focus of increasing attention only within the last 10 years. Equity was the focus of the most recent World Development Report (World Bank 2005), which examined differences in life chances (or opportunities) in terms of explanatory variables such as nationality, race, gender, and social groups. A central thesis of the report is that inequalities in life chances - particularly related to education and health – should be understood as missed development opportunities. The report also argues that greater equity is good for poverty reduction “through potential beneficial effects on aggregate long-run development and through greater opportunities for poorer groups within any society” (World Bank 2005).

The health in fragile states literature has seen recent expansion due to the concern that the burden of ill health in fragile states poses a fundamental challenge to the worldwide campaign to achieve the Millennium Development Goals (MDGs). For example, a recent Department for International Development (DFID) document concludes that “the MDGs cannot be achieved without more progress in fragile states”, and offered recommendations for improving the effectiveness of aid in fragile state contexts (DFID 2005). A World Health Organization (WHO) report on the MDGs paid particular attention to fragile states, noting that they are the countries in greatest need of aid because although they contain only one sixth of the people living in the developing world, they contain a third of people living on less than US$ 1 per day, are responsible for a third of all maternal deaths and nearly half of all under-five deaths (World Health Organization 2005).

There has been no systematic attempt to link the fields of ‘health equity’ and ‘health development in fragile states’. The Health Systems Knowledge Network, part of the WHO Commission on Social Determinants of Health, concluded that that a paucity of data from conflict and post-conflict settings made it difficult to delineate pragmatic ways of creating better social conditions for health for vulnerable populations in conflict-affected countries. This paper was commissioned the Health Systems Knowledge Network to at least begin a more systematic examination of health equity in conflict-affected fragile states. The paper addresses the following key questions:

- What are the main factors that threaten health equity and health care equity in conflict and post-conflict countries? Which populations are most vulnerable to worsening inequity under these situations?
- What strategies can reduce the impact of these factors? In particular what steps need to be taken to both build the foundation for future change and address immediate needs?
What are the roles of different actors at national, regional, and global level in developing and implementing these strategies?

This paper is an initial exploration of a complex topic that clearly needs a great deal more research before definitive conclusions can be reached about how to intervene effectively to promote health equity in conflict-affected fragile states. However, we have identified a number of important issues related to the use of the equity concept in conflict-affected settings, as well as the key drivers of health inequity in such settings. The paucity of equity focused analysis and lack of evidence make it difficult to be dogmatic about conclusions and to make specific recommendations, not least because context is so important in fragile state settings.

2. METHODOLOGY & STRUCTURE

Given the paucity of data on strategies to promote equity in conflict affected fragile states, a broad based approach to data collection was adopted:

1. A review of published and grey literature. Papers were identified through a systematically searching a relevant academic database (Pubmed) and hand-searching relevant journals. Key words included: health, equity, conflict, low-income countries, and fragile states. The grey literature was collected by the authors from various relevant conferences and meetings (including the High Level Forum on the MDGs) that the authors have attended over the last six years. In addition, the websites of key organisations known to be active in the area of service delivery in fragile states were searched. Documents were also collected from various key informants (academics, NGOs, UN and World Bank colleagues), including those who were interviewed.

2. Key informant interviews to tap into experiential perspectives. Semi-structured interviews were conducted with a limited number of key informants, selected because of their experience and knowledge about health and health service delivery in fragile states. Interviews were requested with eight key informants, and five were interviewed; they included individuals from a variety of stakeholder agencies, including representatives of two academic institutions, an NGO and a UN agency. The interviews were conducted by phone, and notes were taken that included key verbatim quotes. A summary was prepared immediately after the interview and sent to the key informant electronically for comment.

3. Analysis of some pre-existing data. A World Bank data set and data collated by DFID were analyzed to provide baseline data on health equity and equity with respect to a few key social determinants of health for fragile states (conflict and non-conflict affected) as well as low income countries.
3. CONCEPTUAL FRAMEWORK

3.1 Defining ‘equity’ and ‘social determinants of health’

We use the definitions of ‘equity’ and ‘social determinants of health’ (SDH) set out by the Commission on Social Determinants of Health:

Health equity can be defined as the absence of unfair and avoidable or remediable differences in health among populations or groups defined socially, economically, demographically or geographically. Health inequity involves more than mere inequality, since some health inequalities (e.g., the gap in average life expectancy between women and men) cannot reasonably be described as unfair, and some are neither preventable nor remediable. Inequity implies a failure to avoid or overcome inequalities in health that infringes human rights norms or is otherwise unfair. Health inequities have their roots in social stratification. (Solar, Irwin et al. 2005)

The social determinants of health (SDH) can be understood as the social conditions in which people live and work... SDH point to both specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts. The SDH that merit attention are those that can potentially be altered by informed action. (Solar, Irwin et al. 2005)

3.2 Defining ‘fragile’, ‘conflict’ and ‘post-conflict’ states

There is no agreed list of fragile states. Indeed, there has been considerable discussion over the last five years about how to define fragile states and what terminology should be used to describe them. For example, they have been called fragile states, difficult partnerships, difficult environments, lower income countries under stress (LICUS countries), and weak, failing, and failed states. However, since early 2005, consensus has formed around the term fragile states and to a lesser extent, the adoption of DFID’s definition, which we will use for the purposes of this paper:

... DFID’s working definition of fragile states covers those where the government cannot or will not deliver core functions to the majority of its people, including the poor. The most important functions of the state for poverty reduction are territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people sustain themselves. (page 7) (DFID 2005)

The list of fragile states that has been adopted is the World Bank’s list, which assigns fragile state classification to a country if it is in the bottom two quintiles of the Country Political and Institutional Assessment (CPIA) rating or has not been rated by the World Bank (see DFID, 2005) for the full list with associated key health and SDH indicators). The CPIA rating is produced by comparing countries’ current performance against 20 criteria grouped into four categories: economic management, structural policies, policies for social inclusion and public
sector management & institutions. It is used to allocate resources to low-income countries from the International Development Association (IDA). As the operational cut-off for IDA eligibility is a 2002 gross national income per capita of $865, all eligible countries are low income states. The list currently contains 46 countries, consisting of 39 countries that appeared at least once in the bottom two quintiles plus 7 countries that were not rated. They have a combined population of 871 million people, or 14% of the world’s population (Branchflower, Hennell et al. 2004).

The paper focuses on conflict-affected fragile states, as opposed to fragile states more generally. From this list of 46 countries, we have focused on the sub-group of 23 countries considered to be conflict-affected because they are affected by an ongoing conflict or are post-conflict states. We have used a categorisation (and sub-categories) established by the Center for Global Development (Center for Global Development 2004), which defines countries to be conflict-affected if there were any battle-related deaths in any given year between 1998-2003. Major war is defined as any conflict with at least 1,000 battle-related deaths in any given year over 1998-2003. Intermediate war is defined as any conflict with at least 25, but fewer than 1,000 battle-related deaths in any given year and an accumulated total of at least 1,000 deaths over 1998-2003. Minor war is defined as any conflict with at least 25 battle-related deaths in any given year and fewer than 1,000 battle-related deaths over 1998-2003. The cumulative population of the 23 countries included in this list is 593 million, with 212 in Indonesia alone; 15 countries are in Africa, with a cumulative population of 235 million.

Once a country has had a civil war, it faces a high chance of recidivism. According to one study, “the typical country reaching the end of a civil war faces around a 44 percent risk of returning to conflict within five years. One reason for this high risk is that the same factors that caused the initial war are usually still present” (Collier, Elliot et al. 2003). This high rate of relapse has profound effects for health and health equity, and any investments in health equity can be put at risk by further conflict.

Data relating to fragile states in the statistical tables presented in this document are restricted to this list of conflict and post-conflict countries. However, because there is so little relevant literature specific to these countries, our case studies are drawn from a broader group of countries including those that are now many years post-conflict, but for which interventions implemented within 5 or 10 years of the conflict are documented in the literature. To enable a comparison between fragile and non-fragile developing countries, we have also used data from the World Bank’s HNP/Poverty Country Report Project which has recently collated the data from Demographic and Health Surveys (DHS) surveys in 56 developing countries, 19 of which appear on the CPIA-based list of fragile states.

The authors acknowledge that caution is required in using such systems of classification, a caution that is reinforced by the poor quality of data that is available for fragile states as a direct consequence of their weak governance. Context is central to health equity issues and health system reform in fragile states, a point that is discussed later in the paper.

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1 For instance, the CGD classification was chosen because it is simple and easy to understand, however: (1) it is not up-to-date, taking into account conflicts between 1998 and 2002; (2) the number of battle-related deaths may not correlate with impact on health, health systems or equity.
3.3 Conceptual framework for this analysis

To our knowledge, there exists no framework for examining the interaction between health equity and health systems in conflict or post-conflict states. Consequently, we have developed a framework that draws heavily on equity frameworks developed by other authors for developmental contexts.

The starting point for this framework is a categorization of social determinants which was developed by Finn Diderichson (Whitehead, Diderichsen et al. 2000; Diderichsen, Evans et al. 2001) and which underlies the conceptual framework of the Commission on Social Determinants of Health (CSDH) This framework identifies four types of social determinants:

I. **Social stratification** – Social stratification assigns people to different social positions, which in turn determine their health opportunities. Social stratification occurs along the lines, for example, of education, occupation, income and gender.

II. **Differential exposure** – Exposures may vary between social groups by type, amount, and duration. For example, in the developing world, the exposures associated with living in an impoverished setting include air- and water-borne diseases such as diphtheria, tuberculosis, cholera, typhoid, infectious hepatitis, yellow fever, and malaria.

III. **Differential vulnerability** – Even when a given risk factor is distributed evenly across social groups, its impact on health may be unevenly distributed due to underlying differences between social groups in their vulnerability or susceptibility to that factor. For example, vulnerability to ill health among African women may stem from their lack of access to education, greater burden of work, and minimal income-generating possibilities. In conflict affected countries, specific groups (IDPs, ethnic groups etc.) may have much higher rates of malnutrition, which significantly increases vulnerability to infectious diseases.

IV. **Differential consequences of disease** – The impact of a certain health event differs depending on an individual’s or family’s socio-economic circumstances or health. For example, in a system without social safety nets, poorer groups have less of a financial cushion, and may face significant barriers to accessing care; if they cannot access any care, the consequences of a disease episode may be more severe, or alternatively, the cost of accessing care for an episode of illness may tip them into long term poverty.

As can be seen in Figure 1, the health system is an important mediator of differential exposure (e.g. due to a failure to control epidemic outbreaks in vulnerable groups). It is also an important mediator of differential vulnerability, differential consequences, and via its impact on differential consequences, it can reinforce social stratification. Differences in social determinants result in health inequities.

Figure 2 provides examples of health inequities that are not unique to periods of conflict or post-conflict, that may result from differential consequences, vulnerability and exposure to disease. For example, the poor may go into debt or find new income sources to pay for health care because of differential access to curative and rehabilitative health care.
Figure 1. WHO Equity Team social determinants framework

Social strata: Gender, Race, Religion, Occupation, Income, Education Etc.

Differential exposure
Exposures may vary between social groups:
- Occupational injury more likely among poor, informal-sector workers
- Low social position associated with greater risk of toxic exposure
- Impoverishment associated with air- and water-borne diseases such as tuberculosis, typhoid, malaria
- Smoking more likely among less educated

Differential vulnerability
Social strata may impact on resilience to disease:
- Restricted mobility for women may mean less access to preventive care, e.g. blood pressure check-up
- Those living in remote rural areas might have less access to childhood vaccines
- Those with less education might not receive preventive health messages

Differential consequences of disease
Impact on socio-economic circumstances:
- Poor may go into debt, or find new income sources, to pay for health care
- Loss of limb may mean job loss for a manual labourer but not for a teacher
- Poorer heart attack patients may be less likely to receive a standard/approved regimen of care
Figure 3 provides examples as to how these differentials (i.e., differences in social determinants) may be exacerbated in conflict and post-conflict settings. For example, one of the major consequences of prolonged conflict is increased exposure to infectious diseases, particularly among groups displaced by conflict. A particularly important point that we have tried to incorporate into our framework, is that the fundamental driver of inequity in health and SDH in conflict-affected fragile states is conflict, and indeed state fragility itself; the corollary of this is that to address health inequalities in conflict-affected fragile states you have to address security issues and as well as state fragility (as we will discuss later in this paper).

**Figure 3. Drivers of health inequity in conflict-affected fragile states**

To further develop the framework as a potential tool for addressing health equity in fragile states via the health system, we next incorporated categories developed for classifying interventions in the health sector (Figure 4) (Berry, Forder et al. 2004). Health sector (and
specifically health equity) interventions in conflict or conflict-settings can be categorized based on whether they:

- Strengthen equity-oriented policy making functions;
- Build provider capacity (to provide services for targeted groups, or move towards universal coverage);
- Reduce barriers to access and participation among disadvantaged groups including poor people, IDPs, and socially marginalized groups (ethnicity, religion, gender).

Thus, we end up with a matrix for classifying health equity interventions based on: type of health inequity (or social determinant) addressed and ‘level’ of the health sector at which the intervention will be implemented. Figure 4 provides examples of interventions that might fall into each cell of this matrix. The matrix has the benefit of including interventions from outside the health sector (e.g. water, sanitation, education). However, it should be noted that these examples are hypothetical and not yet informed by the literature from conflict-affected settings.

**Figure 4. Addressing health inequity in conflict-affected fragile states via interventions at different levels**

<table>
<thead>
<tr>
<th><strong>Conflict-affected fragile state context</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social strata:</strong> Gender, Race, Religion, Occupation, Income, Education Etc.</td>
</tr>
<tr>
<td><strong>Differential exposure</strong></td>
</tr>
<tr>
<td>- Policies related to maintaining security improved nutrition, water, sanitation, reduced occupational and environmental exposures</td>
</tr>
<tr>
<td>- Nutritional interventions</td>
</tr>
<tr>
<td>- Improved epidemic surveillance and outbreak control</td>
</tr>
<tr>
<td>- Community-based groups to improve water or sanitation infrastructure</td>
</tr>
<tr>
<td>- Investment in essential infrastructure to improve equity of access (water, sanitation, shelter, transport ....)</td>
</tr>
<tr>
<td><strong>Differential vulnerability</strong></td>
</tr>
<tr>
<td>- Expanding coverage with preventive health interventions</td>
</tr>
<tr>
<td>- Policies to increase receptiveness to health messages (e.g. increase literacy among women)</td>
</tr>
<tr>
<td>- Data collection to enable identification of existing health inequalities</td>
</tr>
<tr>
<td>- Targeted measles vaccination program, with vitamin A supplementation</td>
</tr>
<tr>
<td>- Information campaigns to address knowledge barriers to accessing care, increase knowledge about health promotion (e.g. hand washing)</td>
</tr>
<tr>
<td>- Removal of user fees for preventative services such as vaccination</td>
</tr>
<tr>
<td><strong>Differential consequences of disease</strong></td>
</tr>
<tr>
<td>- Data collection to allow evidence based pro-equity policy making.</td>
</tr>
<tr>
<td>- Commitments to: establishing social safety nets; universal coverage with curative care ...</td>
</tr>
<tr>
<td>- Restore curative care in rural areas</td>
</tr>
<tr>
<td>- Utilization of contracting out to NGOs to enable rapid roll out of a basic package of care (e.g. Afghanistan)</td>
</tr>
<tr>
<td>- Address financial access barriers: avoid user fees/ introduce exemptions/ targeted voucher schemes</td>
</tr>
<tr>
<td>- Address geographical access barriers (address deficits in: security; transport infrastructure; geographical coverage of health services).</td>
</tr>
</tbody>
</table>

**Broad-based inter-sectoral action to address state fragility:**

- Peace keeping/peace enforcement/peace building
- Fostering functioning and effective states
- Investing in human resources
- Accelerating economic growth
A single intervention can simultaneously address several different categories of social determinants. For example, in Afghanistan, contracting the provision of basic health services has led to a rapid increase in coverage of basic health services (Palmer, Strong et al. 2006). This should have an impact in terms of differential consequences of disease (for example, via increasing access to key curative services), and on vulnerabilities (for example, increased measles immunization coverage will decrease under five mortality).

In the following sections, this paper will outline some possible strategies to address health inequity within this framework, as a first step towards providing pragmatic advice to health planners and policy makers in conflict-affected fragile states on the best ways to address health equity both during conflict, and after conflict.

4. THE IMPORTANCE OF HEALTH EQUITY IN CONFLICT-AFFECTED STATES

There are a variety of reasons why health policy makers at the national and international level should pay particular attention to health equity across countries and within conflict-affected states. This section discusses two important reasons:

- Conflicted-affected states have poor health outcomes, even relative to non-conflict affected fragile states, thus contributing to cross-country health inequity. Imbalances in aid flows may exacerbate these inequities.
- Conflict can increase within country health inequities, and differentials in the social determinants that underlie them.

4.1 Conflict affected states contribute to cross-country health inequity

From a global perspective, conflict clearly has significant implications for health equity. There is a substantial literature on the impacts of conflict on health and health systems (for example, Davis, 2001; (Zwi, Ugalde et al. 1999; Davis and Kuritsky 2001). Conflict is known to have a negative impact on social and economic conditions (Stewart and Humphreys 1997) and health indicators in general (Ityavyar and Ogba 1989; Garfield and Neugut 1991; Toole 1997; Zwi, Ugalde et al. 1999). Case studies include Ethiopia (Barnabas and Zwi 1997; Kloos 1998), El Salvador (Ugalde, Selva-Sutter et al. 2000), Democratic Republic of Congo (Goma Epidemiology Group 1995; Roberts 2001), Uganda (Dodge 1990; Macrae, Zwi et al. 1996), Kosovo (Spiegel and Salama 2000) and Iraq (Daponte and Garfield 2000; Burnham, Lafta et al. 2006). It has been estimated that the number of direct deaths attributable to violence is increasing, such that by 2020, war will rank 8th in the global burden of disease league tables, alongside HIV/AIDs, tuberculosis and malaria (Murray and Lopez 1996; Krug, Sharma et al. 2000). However, a more recent study by the Human Security Centre found that both the number of conflicts and the number of direct deaths due to violence have decreased since the end of the Cold War (Human Security Centre (University of British Columbia) 2005). There is very little global data on indirect deaths caused by disease and malnutrition, but it is evident that they cause the majority of deaths in conflict (Connolly and Heymann 2002; Coghlan, Brannan et al. 2006).
Promoting Health Equity in Conflict-affected Fragile States

Key health and SDH indicators are worse in fragile developing countries compared to non-fragile developing countries. Table 1 compares different categories of fragile state defined by whether or not they were conflict-affected, and the severity of the conflict for conflict affected states. Nigeria and Indonesia were excluded in the analysis, because their populations are so much greater than those of the other fragile states. In general terms, it is obvious from the table that conflict-affected states are significantly worse off in terms of the key health and SDH indicators presented. Furthermore the worse the conflict, the worse the indicators become. There are some indicators that are difficult to explain – e.g. the higher annual per capita growth rates in conflict affected fragile states, and clearly a more detailed analysis (which is outside the scope of this paper), would be required to explore this.

Table 1. Weighted averages of key health and SDH indicators for conflict-affected and non-conflict-affected fragile states *

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All fragile states</td>
<td>303.3</td>
<td>25.1</td>
<td>1.2</td>
<td>43.9</td>
<td>60.7</td>
<td>62.5</td>
<td>37.9</td>
</tr>
<tr>
<td>Non-conflict-affected</td>
<td>425.4</td>
<td>30.2</td>
<td>0.0</td>
<td>46.2</td>
<td>64.4</td>
<td>68.5</td>
<td>31.0</td>
</tr>
<tr>
<td>All conflict-affected</td>
<td>249.9</td>
<td>23.2</td>
<td>1.8</td>
<td>43.0</td>
<td>59.2</td>
<td>59.8</td>
<td>40.2</td>
</tr>
<tr>
<td>Affected by major conflicts</td>
<td>207.6</td>
<td>24.2</td>
<td>1.6</td>
<td>34.6</td>
<td>53.3</td>
<td>48.4</td>
<td>49.1</td>
</tr>
<tr>
<td>Affected by intermediate conflicts</td>
<td>272.5</td>
<td>15.3</td>
<td>4.2</td>
<td>50.3</td>
<td>68.1</td>
<td>84.8</td>
<td>24.7</td>
</tr>
<tr>
<td>Affected by minor conflicts</td>
<td>379.5</td>
<td>28.8</td>
<td>-0.2</td>
<td>64.7</td>
<td>70.8</td>
<td>61.3</td>
<td>26.2</td>
</tr>
</tbody>
</table>


These cross-country inequities may be exacerbated by imbalances in aid flows to low-income countries. For example, there is evidence that fragile states in general receive a disproportionately small share of aid financing. In 2001, for example, fragile states did not receive as much aid as non-fragile states from the world’s donors (Figure 5) (DFID 2005). “Fragile states, proxied here as the bottom 40% of countries on the CPIA score (quintiles 4 and 5), received only 14% of bilateral aid, whereas the top 40% (quintiles 1 and 2) received two-thirds of all aid, or nearly five times as much” (DFID 2005).
And among the fragile states, conflict-affected states may be at particular disadvantage, a contention borne out by our analysis presented in Table 1 which shows that conflict-affected fragile states receive less ODA per capita than non-conflict-affected fragile states.

Another example of this is provided by the fact that the World Health Organization (WHO) faces greater difficulty in mobilizing funds for fragile countries experiencing protracted conflicts:

*Sudden emergencies and natural disasters get more public attention than protracted long-term crises. The WHO components of the flash appeals for funding launched in 2005 immediately after sudden emergencies achieved a funding rate of 83% of what was required. By contrast, ongoing appeals received only 44%, confirming the great contrast between high-profile emergencies in countries such as Sudan, Iraq or Uganda and the so-called “forgotten emergencies” in countries such as Eritrea, Central African Republic, Democratic Republic of the Congo and Guinea.* (WHO - Health Action in Crises 2006)

### 4.2 Conflict can cause or exacerbate within-country inequities

The impact of conflict on health equity and the distribution of social determinants of health is not very well documented. Very few empirical studies have actually measured health equity in conflict-affected states, but those that have suggest that conflict has a significant impact. A recent study for example – which analysed data from Bangladesh, Benin, Brazil, Cambodia, Eritrea, Haiti, Malawi, Nepal, and Nicaragua to assess how preventive (“child survival”) interventions are clustered at the level of the individual child (Victora, Fenn et al. 2005) – suggests that recent conflict has a significant negative impact on child survival. The percentage of children who did not receive a single intervention ranged from 0·3% (14/5495) in Nicaragua to 18·8% (1154/6144) in Cambodia. There were substantial inequities within all countries, but the situation was especially severe in those recently affected by conflict - Cambodia, Eritrea, and Haiti. For example, in Cambodia, children from the least poor quintile were 2.1 times
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more likely than those from the poorest quintile to receive three or more interventions, and 18.6 times more likely to receive six or more interventions. Authors suggest that differences in inequity within countries may be explained by the amount of time that has lapsed since the interventions were first introduced. In conflict-affected countries, such as Eritrea and Cambodia, coverage at the time of the surveys was concentrated in the higher economic groups. The authors hypothesize that coverage will gradually increase among those in the middle and lower classes if the interventions continue to be promoted.

In Table 2 we present median values for five key indicators of within country inequity in 19 fragile-states and 37 non-fragile-state low-income countries (unweighted averages were also calculated and reveal a similar picture).

Table 2. Median values for key health and SDH indicators for 19 fragile- compared to 37 non-fragile developing countries*

<table>
<thead>
<tr>
<th>Health or SDH Indicator (Medians)</th>
<th>Median values for 19 Fragile States**</th>
<th>Median values for 37 Non-Fragile Developing Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Socio-Economic Quintile</td>
<td>Median of the averages</td>
</tr>
<tr>
<td></td>
<td>Lowest</td>
<td>Highest</td>
</tr>
<tr>
<td>Under-five mortality rate (median number of deaths under 5 years per thousand live births)</td>
<td>163.1</td>
<td>97.0</td>
</tr>
<tr>
<td>Nutritional status (median for severe stunting - % of children under 5 whose height for age is below -3 sd z-score)</td>
<td>21.1</td>
<td>9.3</td>
</tr>
<tr>
<td>Basic immunisation coverage (median % of children age 12-23 months who have received BCG, measles, and DPT)</td>
<td>25.0</td>
<td>59.9</td>
</tr>
<tr>
<td>Access to maternal care (median % of births assisted by a medically trained person)</td>
<td>12.2</td>
<td>81.2</td>
</tr>
<tr>
<td>Access to basic education (median % of girls in the household age 6-10 years old who currently attend school)</td>
<td>30.2</td>
<td>77.6</td>
</tr>
</tbody>
</table>


The median values for all indicators were worse in the fragile-states compared to the non-fragile states. The median values for lowest/highest quintile ratio were also compared. This ratio is a measure of within-country inequity. The higher it is above 1 for morbidity/mortality indicators, the greater the inequity; the lower it is below 1 for coverage/access indicators, the greater the inequity. This ratio suggests that fragile states are less equitable in terms of immunization coverage and access to maternal care and basic education. But unexpectedly,
fragile states are more equitable than the non-fragile states in terms of under-five mortality rate and nutritional status, an observation that we would suggest is the result of a levelling down affect secondary to the collapse of the health system.

These findings should be interpreted with some caution – they are based on simple, descriptive analyses. However, our preliminary analysis suggests that the large DHS data sets of the World Bank could be used as the basis for further research that would be more rigorous than our initial descriptive analysis (we did not have access to the full data set and were unable to control for confounding etc. via multiple regression). Examining the temporal correlations between armed conflict and levels of within-country equity could be particularly informative. If conflict is, in fact, sometimes associated with improved equity in health outcomes (albeit at a lower level), the most likely explanation is that conflict results in worsening of health among the entire population, but the effect is greatest among those who previously had the most favourable health outcomes, i.e. the highest quintile by socio-economic status. This suggests that in interpreting equity indicators in conflict-affected environments you need to take account of the absolute levels of the indicators via comparison with non-conflict affected countries as well as intra-country inequities.

There is evidence that conflict can be a primary driver of health inequalities, as starkly illustrated by Coghlan et al (2006) in their mortality study of the Democratic Republic of the Congo (DRC). This is one of a few studies in the literature with sufficient power and geographical coverage to allow a meaningful analysis of geographical inequities in mortality related to conflict. They found that mortality rates in conflict affected areas were two to three times those in non-conflict-affected areas (Table 3).

**Table 3. Mortality rates in the Democratic Republic of the Congo**

<table>
<thead>
<tr>
<th>Health zones reporting violence</th>
<th>Crude mortality rate (Deaths/10,000/day) (95% CI)</th>
<th>Under-5 mortality rate (Deaths/10,000/day) (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.0 (2.6-3.4)</td>
<td>6.4 (5.7-7.2)</td>
</tr>
<tr>
<td>Health zones not reporting</td>
<td>1.7 (1.5-1.9)</td>
<td>3.1 (2.7-3.5)</td>
</tr>
<tr>
<td>violence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Crucially, they concluded that to redress these inequalities it is necessary to address insecurity: “Reductions in mortality are closely associated with reductions in violence and, by extension, improvements in security …”. Furthermore, they concluded that their results “provide compelling evidence that improvements in security represent perhaps the most effective means to reduce excess mortality”. Others have made similar observations (Waldman 2006), as did a number of our key informants, who highlighted the centrality of improving security to addressing inequity in fragile states.

Differential impacts are mediated in conflict-affected environments by socio-economic status and other social characteristics that increase vulnerability. In broad terms, these impacts can be categorized as follows: inequities resulting from geographical barriers to accessing health care and the development of islands of relevant privilege; gender-based inequities; inequities resulting from increased financial access barriers and the collapse of the financial protection.
function of the health system that disproportionately affects the poor and sick; inequities related to displacement status (IDPs, refugees, and ‘stayees’) and other characteristics such as ethnicity, and religious or political affiliation; and reduced capacity for equitable health policy making, planning and implementation.

**Geographic Disparities in Access to Health Care and Health Status**

The literature on the overall impact of conflict on health systems (or public health) makes some direct mention of inequities (Zwi, Ugalde et al. 1999). A recurring theme is the development of inequalities mediated by geographical access barriers. The importance of this issue to health equity in conflict affected states was also stressed by number of key informants. They highlighted the interplay of security and the degradation of transportation infrastructure, which affect the ability of people to travel to services, as well as geographical coverage deficits due to destruction of infrastructure and loss of health workers. Together these worsen geographical access more in some areas then others, as happened in South Sudan, Liberia, the DRC, Mozambique, and northern Uganda.

In general terms, the health system in rural areas is often more affected by conflict compared to urban areas. Insecurity and the loss of income pushes health workers to relocate to urban areas or emigrate. Primary health care services tend to be more affected than hospital based services, and preventative services are affected more than curative services, which people are more prepared to pay for (Zwi, Ugalde et al. 1999). Macrae (Macrae 1995) documents such rural-urban inequities in Uganda, and suggests that they may have a long-term impact. A combination of ethnic division, fear of reprisals and injury affected the distribution and availability of health resources in Soroti, a northern district of Uganda affected by conflict between 1986 and 1992. Particularly important was the transfer of resources from rural to urban areas, and the fact that it was the most senior and skilled health professionals who left first.

As noted above, Coghlan et al (2006), in their recent paper on mortality in the DRC, graphically illustrate the impact that conflict can have on geographical inequalities in mortality both within and between countries:

*The national crude mortality rate of 2.1 deaths per 1000 per month (95% CI 1.6–2.6) was 40% higher than the sub-Saharan regional level (1.5) ... the rate was higher in unstable eastern provinces, showing the effect of insecurity. Most deaths were from easily preventable and treatable illnesses rather than violence. Regression analysis suggested that if the effects of violence were removed, all-cause mortality could fall to almost normal rates* (Coghlan et al, 2006).

A number of the key informants pointed out that geographical inequalities in health are not always worsened by conflict. HIV/AIDS is a case in point. Conflict can actually protect against HIV/AIDS if it has the effect of isolating communities or geographic areas, so cutting down transmission via trucking routes, or by seasonal and work related migration (Spiegel 2004). For example HIV infection rates in Angola are low compared to other sub-Saharan countries, and the isolation as a result of the prolonged conflict is said to be a major part of the explanation
for this. The impact of conflict on prevalence rates depends very much on the dynamics of local transmission – in areas with high prevalence, rape as a weapon of war may increase the transmission of HIV. If prevalence rates are low, the challenge in the post conflict period is to take advantage of this window of opportunity and maintain low prevalence rates via effective post-conflict HIV/AIDS policy making and service provision (Spiegel 2004).

**Inequalities Mediated by Displacement Status**

Displacement is a significant factor driving inequities in both health status as well as access to SDH. In general, camp-based populations tend to be less vulnerable than non-camp based populations (Salama, Spiegel et al. 2001). However, one of the highest crude mortality rates (CMRs) in a humanitarian emergency ever recorded was amongst Rwandan refugees in Goma in 1994, when the CMR reached 20-35 deaths per 10,000 people per day (Goma Epidemiology Group 1995). Very high CMRs have also been recorded amongst IDPs; in Sudan and Somalia, daily mortality rates topped eight per 10,000 and 17 per 10,000, respectively, significantly higher than the emergency response threshold of one death per 10,000 people per day (Toole and Waldman 1993). In 1999, during the Kosovo crisis, CMRs in refugee camps in Albania and Macedonia remained low at 0.1/10 000/day. However, within IDP populations in Kosovo itself, the CMR peaked at 1.1/10 000/day (Spiegel and Salama 2000), making the CMR in IDPs over ten times that of refugees. Outbreaks of vaccine preventable and other diseases (i.e. differential vulnerability) contribute to these high mortality rates, for example the outbreaks of measles recorded in the DRC, and the shigella and cholera outbreaks in Rwanda (Salama, Spiegel et al. 2004).

Although data is scarce, rates of morbidity are often higher amongst IDPs than refugees. For example, some of the highest prevalence rates for malnutrition (which increases vulnerability to infectious diseases and worsens the consequences of infections) that were recorded in the 1990’s were in IDP populations during famines in conflict affected countries: in 1998, MSF recorded prevalence rates for severe acute malnutrition of 36% in southern Sudan; in 2000 MSF recorded a large outbreak of pellagra in Angola, with attack rates among IDPs more than twice that of non-displaced people (Salama, Spiegel et al. 2001).

IDPs are forced to leave their homes for similar reasons to refugees, but because they have not crossed internationally recognised borders they are not entitled to the same legal protection under international law as refugees. No specific international humanitarian agency is mandated to provide them with humanitarian assistance or protection (Borton, Buchanan-Smith et al. 2005). It is likely that both these factors contribute to these differential health outcomes.

However, as some of our key informants pointed out, refugees and IDPs can sometimes have better access to health services than host populations or stayees (i.e. those who are unable or unwilling to leave their homes), and their health may actually improve as a consequence of their displacement. This paradox can be explained with reference to their poor pre-conflict access to health care and SDH – moving to a refugee camp allows them to access health and education services provided by externally funded NGOs, INGOs or UN organisations, improves their nutritional status, and gives them access to clean water and improved sanitation. In the literature, the phenomenon is referred to as the creation of “islands of relative privilege”: 
Health sectors respond to crisis in many ways. Because of external funding, easy access and better security conditions, islands of relative privilege, may emerge in areas where deprivation is rife. Thanks to the presence of humanitarian actors, areas affected by violence may be better served than other comparatively peaceful ones… (page 8) (High-Level Forum on the Health MDGs 2005b).

There are numerous examples of this phenomena (see Box 1 below). In Liberia and Chad, recent inter-agency health and nutrition evaluations (Sondorp 2005; Michael, Pearson et al. 2006) showed that refugees and IDPs were better serviced than stayees (the sub-population that remained in their normal areas of residence) and/or the host population. In Guinea (Lawrie and Van Damme 2003) and Uganda (Rowley and Burnham 2003), humanitarian agencies integrated host populations into refugee services to address this equity issue.

Box 1. Paradoxical improvements in health equity in conflict settings: Good pregnancy outcomes among refugees in Africa

The 1998 UNHCR compilation of service and survey data from eight sites showed a wide range of low birth weights: 3% of infants in Uganda; 6% in Zaire; 9% in Ethiopia; 10% in Nepal; and 22% in Tanzania (Bitar 1998). Except in Tanzania, refugees experienced low birth weight at lower rates than did populations in their home or host countries. Neonatal death rates at these sites ranged from 10 (in Uganda) to 29 (in Tanzania) deaths per 1,000 live births, and were lower in all sites than among populations in the home and host countries… (page 175) (McGinn 2000)

The primary explanation proffered for good pregnancy outcomes among refugees is the availability and use of health services. Such an explanation is supported by a review of emergency obstetric care available to refugees in eight sites in Africa (Guinea, Kenya, Liberia, Lebanon, two sites in Rwanda and two sites in Sudan) (Purdin 1999). Refugees in all sites had access to at least some emergency obstetric services. In four sites, care was available locally or within one hour’s travel; other sites required 3-8 hours’ travel. Nongovernmental organizations working in these camps or other authorities typically provided transport for emergencies. In virtually all of the camp situations, the emergency and other services available to refugees were better—in quantity and quality—than that which existed in their home country during and, in most cases, prior to the conflict that made them refugees (McGinn 2000).

With regards to HIV/AIDS and displacement status, (Spiegel 2004) reports that HIV prevalence is less in many refugee population compared to host populations, and that refugees have much better access to HIV and other health services. For example, in northern Kenya, the HIV prevalence rate among refugees is 5 percent, compared with 18 percent in the surrounding population. Presumably this inequity in health status is mediated via differential vulnerabilities and exposures. Furthermore, if the refugees have better access to services – which has been documented in other settings – you would expect there to be differential health consequences due to differential access to preventive and curative services, for example, provision of free
condoms, PCP prophylaxis, treatment for sexually transmitted infections and treatment for opportunistic and other infections.

**Gender-based Inequities**

Women and girls constitute the majority of IDPs and refugees worldwide. In terms of the health impacts of conflict on civilian populations, women are recognised as being a particularly vulnerable group.

*Along with reproductive health complications, the adverse effects of conflict hit women and girls harder than it does their male counterparts, since deliberate gender-based violence and discrimination are rampant in these settings. As such, these gender-specific threats to women and girls compound the challenges of ensuring their protection. (UNFPA 2003)*

As Palmer and Zwi have noted in their paper on the influences of gender differentials on health in conflict settings: “Gender affects exposure to situations which have an impact on health, dictates who has access to health-care services, and influences its planning and provision” (Palmer and Zwi 1998). They argue that involving women in the planning and delivery of services is essential to redressing this inequity.

The area of reproductive health is somewhat unique, in that health inequities (gender-based) in conflict and post-conflict have been well documented, and concrete recommendations made as to how these inequities should be addressed (see Box 2). This focus on reproductive health among war-affected populations came about only in the mid-1990s, as a result of several events (McGinn 2000). For example, the scope and coverage of atrocities, particularly sexual violence, committed during the conflicts in the former Yugoslavia and in Rwanda drew world attention to reproductive health issues.

**Box 2. Tackling gender-based violence among Burundi refugee women in Tanzania**

The results of an International Rescue Committee (IRC) assessment of the prevalence of sexual and gender-based violence (SGBV) among Burundi refugee women in Tanzania showed 27% of randomly selected women 12-49 years old had been raped since becoming refugees. A multi-sectoral SGBV programme involving several NGOs, UN agencies, Tanzanian Government staff (police, ministries) and the refugee community was implemented. Main sectors involved in the programme were protection, community support, security and health.

The objective of the health programme, implemented in conjunction with other sectoral programmes, was to provide appropriate health examination and treatment to prevent unwanted pregnancy. One major step was the establishment of a 24-hour drop-in centre staffed by refugee women, located in the maternity wing of the camp medical facility. The centre offers a confidential, safe and friendly environment to encourage women to attend. Because the centre offers a wide range of services as well as addressing sexual violence, survivors are not automatically stigmatized for seeking assistance.
Other steps included the training of community health and medical workers to treat survivors in line with guiding principles of confidentiality, respect, security and safety. Health care centres also provide medical examination and treatment, along with medical documentation required for legal proceedings. Source: (Anonymous 2001)

At every stage of a conflict, women and adolescent girls and boys are vulnerable to sexual and gender-based violence. Rape and other forms of violent assault are often used as weapons of war. Women and girls are forced to offer sex in exchange for food, shelter or protection. As a result, gender determines the likelihood of people becoming infected with STIs, including HIV/AIDS; women and girls are significantly more likely to be infected than men and boys. UNFPA report that a recent post-conflict study in Africa revealed that the HIV infection rate in adolescent girls was four times that of adolescent boys (UNFPA 2003). In conflict-affected settings, the inaccessibility of appropriate services such as emergency contraception and other medical and psychological care mean that sexual and gender-based violence has an even more disastrous effect on people’s physical and mental health (Doedens and Burns 2001).

A variety of cultural, economic, legal and political factors perpetuate gender-based violence, including: disturbance of cultural norms and family composition; women’s economic dependence on men; lack of police protection and lawlessness; limited options for legal redress; aggressive behaviour triggered by the psychological strains of refugee life and strong social pressure to maintain the status quo in the face of enemy attack; and travel to remote distributions points for food, water and fuel (United Nations High Commissioner for Refugees 1999; McGinn 2000).

However, it is important to note that while women may suffer more from rape, more men suffer and die from violence in war than women (Garfield and Neugut 1991; Depoortere, Checchi et al. 2004; Republic of Uganda Ministry of Health, WHO et al. 2005). Thus, there are gender inequities in conflict-affected contexts, both in terms of the type of violence and how it affects men and women.

**Inequities due to health financing mechanisms**

In many situations, official salaries are not paid to health staff during conflict. To survive, health professionals have to charge informal payments at public facilities which pose a financial barrier to access among the poor. Cost recovery via such mechanisms is in effect the default setting for health financing. In addition, formal user-fees may be implemented throughout the public health system to compensate for insufficient government health budgets (Macrae 1997; Nabarro 2004) (see Box 3). Both formal and informal user fees may result in catastrophic health care expenditures. While there is little in peer-reviewed journals on the impact of user-fees in the context of conflict-affected fragile states, there are many papers about developing countries that outline their impacts. For example, Xu et al. (2003) identified three key drivers of catastrophic payment — the necessity of payment to access health services, low capacity to pay, and the lack of prepayment or health insurance (Xu, Evans et al. 2003) — all of which are present in conflict affected fragile states. This certainly suggests (although there is very limited data to document it), that given the severity of poverty in conflict-affected
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fragile states, catastrophic health expenditure must be a significant problem. Similarly it is likely that many people in conflict affected environments are unable to access care due to financial barriers.

In-house NGO programmatic assessments, while not conclusive, suggest that the capacity of user-fees to raise significant amounts of money in complex emergencies is very limited ((Poletti 2003). Utilisation rates suggest that the higher the cost of accessing care in complex emergencies, the lower the utilisation will be. For example, MSF, in a retrospective epidemiological survey in Burundi two years after the introduction of user-fees, found that 17% of the population were unable to access health services at all, with 82% of these specifying financial barriers as the explanation. In addition, 81.5% of those who did access services had to borrow money, or sell productive assets to raise the necessary funds (MSF 2004). This indicates that the willingness-to-pay versus ability-to-pay debate is of particular relevance to such settings, given the high levels of extreme poverty; just because people pay user-fees to access services one should not conclude that they can afford to do so.

A particular concern is that little is known about who is discouraged from seeking care by user-fees, and what the impact of their failure to do so might be, although community based surveys suggest that it is the poor, and that catastrophic health expenditure is common ((Poletti 2003). Finally, information regarding the impact of cost-sharing on the health of populations, and particularly its implications for the control of infectious disease (a major source of morbidity and mortality in complex emergencies) is scarce.

Box 3. The Introduction of Cost-sharing by the IRC in Nimba County, Liberia

Faced with a resource gap in the health system as a consequence of the civil war and its economic effects, and declining donor funding, the Liberian Ministry of Health and National Drug Service developed a plan to introduce a nation-wide cost-sharing scheme in 1999. A subsequent review of health care financing, funded by the European Union to assess the potential of a cost-sharing scheme, confirmed that the government health budget was insufficient to meet the operating and treatment costs of the health system.

At that time, there was already a variable fee-for-service (FFS) charge in place that ranged from less than 30 Liberian Dollars\(^2\) (L$) to more than 100 L$ (with drugs provided free of charge). A survey commissioned by the Cost-sharing Scheme Steering Committee suggested that while people were neither willing nor able to pay the full cost of treatment, a cost-sharing scheme that resulted in a total charge of less then 40 L$ for accessing care was supported by the majority of people surveyed. As a result, the FFS was standardised at 10 L$ for adults and 5 L$ for children. In addition, a fee-for-treatment (FFT) charge was levied to partially cover the costs of drugs and other medical supplies used for treating malaria, acute respiratory tract infections, diarrhoeal illnesses, and pre-natal care. It was hoped that this would form the basis for the re-creation of a revolving drug fund within 5 years.

The International Rescue Committee (IRC), which had been involved in the development of the FFT plan, introduced the new measures in the 15 clinics it was already supervising in

\(^2\) One Liberian Dollar was equivalent to 0.02 US$ in 2001.
Nimba County in April 2001. Community Health Committees were formed and made responsible for the management of the FFT funds, setting exclusion criteria (which were not allowed to apply to more then 5% of the population), maintaining a stock inventory, reviewing the efficacy of the FFT scheme and ensuring community support. Clinic staff was responsible for collection of fees, record keeping and drug procurement and supply. Rational Use of Drugs Guidelines were already in place. Three months after the start of the new scheme, an evaluation was carried out (Nguyen 2001a; Nguyen 2001b).

The evaluation report gave little information other than utilisation data; there was no information on the revenue collected from the FFT scheme. The utilisation figures showed a 50-60% drop in clinic consultations compared to the same months in the previous year (which should control for variation due to seasonal factors). The evaluation reported that every community felt that the FFT charge was too high given their incomes and large extended families with high dependency ratios. In the context of a subsistence farming economy with annual incomes of 600-1000 $L, this is not surprising.

NGOs are now advocating strongly against the imposition of user fees in fragile states, supporting this advocacy with primary data collection. For example, MSF on the basis of their work in Burundi, are now advocating strongly against user fees in Burundi. Save the Children UK has also taken a very strong stance against user fees in emergency settings based on various surveys they have done. Donors are also becoming more aware of both the overall health systems impact of conflict, as well as the problem of affordability, and some are discouraging the imposition of user fees in fragile states.

Community health financing is an alternative to user fees as it increases the levels of financial protection that communities enjoy from the financial cost of illness. In post-conflict countries, two community financing strategies that have been tried: health equity funds and community-based health insurance.

Health equity funds have had some impact on hospital utilization in Cambodia. In Thmar Pouck Hospital (Van Damme, Van Leemput et al. 2004), the hospital was linked to a ‘Health Equity Fund’, managed by the local non-governmental organization – the Cambodian Association for Assistance to Families and Widows. This organization identified the poorest patients and paid their hospital fees with a budget donated by MSF. Since the introduction of these initiatives in late 2000, the number of hospitalizations in Thmar Pouck hospital more than doubled. The Health Equity Fund in Thmar Pouck was instituted to make the public health system more attractive and accessible, and to prevent poor people from spending in the private system. A similar Health Equity Fund in Sonikum, Cambodia, was less successful (Hardeman, Van Damme et al. 2004); while the fund was found to effectively improve financial access of the poor, the poor continued to face many constraints to timely access. Particularly problematic were demand side barriers created by a lack of awareness of the fund by the majority of the people who were eligible. Even those who benefited from the fund learned about it only when they presented to the hospital. Both of these observations suggest that the fund did little to reduce uncertainty about (financial) access. In both of these Cambodian cases, the authors emphasize that the equity fund is only one complement to a relatively well-functioning health service, in which health staff are present, drugs available and informal charges absent. This
observation suggests that health equity funds would be of limited use in the immediate post-
conflict settings until a reasonable level of service has been restored.

Evidence from low-income development settings suggests that community health financing
(CHF) schemes such as community-based health insurance (allowing for risk pooling), or pre-
payment schemes (which spread out the cost of health related expenditure over time), can help
to protect against the impoverishing effects of unpredictable health expenditure (Preker and Carrin 2004). However, there are concerns about the ability of such schemes to be inclusive of
the poorest (Bennett, Creese et al. 1998), and there are a significant number of authors who
suggest that the evidence base is too weak to draw firm conclusions about the utility of CHF
(International Labour Office (Universitas Programme) 2002; Ekman 2004).

The evidence on the potential role of CHF in post-conflict settings is extremely limited,
although studies from Rwanda suggest that voluntary, community-based health insurance may
ameliorate the inequitable effects of user fees (Schneider and Hanson 2006). Health care
patients in Rwanda have paid user fees to public providers since 1976. However, in 1999 the
Government in a collaborative effort started 54 micro-health insurance schemes in three rural
districts. In return for an annual contribution, households are covered against the costs of drugs
and services provided by health centres and transport by ambulance to district hospitals, where
a limited number of services are covered. The impact of the schemes was assessed using data
from a household survey conducted in the three Rwandan districts in 2000 (Schneider and
Hanson 2006). Among people who did not have insurance (and so had to pay user fees to
access services), patterns of health care utilization were found to be (horizontally) inequitable –
they observed the normal negative equity impact of user-fees which results in health care
utilisation becoming strongly correlated with socio-economic background. This contrasted
significantly with the situation for insured individuals who reported markedly higher utilisation
rates than the uninsured, and the distribution of visits matched the distribution of their need for
care. The authors conclude that micro-health insurance schemes contributed to (horizontal)
equity of health care utilization.

Reduced Capacity for Equitable Health Policy Making

The emigration of health workers and the breakdown in the financing of health systems have
major effects in terms of national capacity for policy-making, planning and management in
conflict-affected countries (Macrae 1995; Zwi, Ugalde et al. 1999; Bornemisza and Sondorp
2002). This has implications for equity as having sufficient capacity in these areas is a pre-
requisite to ensuring that equity is factored into rehabilitation and health sector reform.

Even if capacity exists, political will to address equity is extremely important, and without
reconciliation, underlying grievance may negatively impact on a systems ability to promote
equitable access for all political or ethnic groups. For example, in Kosovo despite the General
Health Law signed after the conflict, which defined equity as one of the primary objectives of
the health system, health service provision remained divided along ethnic lines because of
continuing distrust between Albanian and Serb Kosovars. (Bloom 2005).
5. STRATEGIES TO IMPROVE HEALTH EQUITY

Improved security is essential before strategies to impact on health equity can be employed. Most of our key informants argued that before the international community and national governments can promote health equity, the underlying causes of the conflict must be addressed, and that any investment in health equity should be supported by a parallel investment in state stabilization. Indeed, the literature suggests that state fragility must be addressed if interventions of any type are to be more effective (Prime Minister’s Strategy Unit 2005) in that governance issues should be addressed and the rule of law established. Armon and Berry et al. (2004) argue in their report on delivering basic services in Nepal that unless democracy is restored and human rights are protected, development progress in Nepal will continue to be severely constrained.

State stabilization is difficult, and policy-makers remain uncertain as to the best way to do this. Some argue that improved basic service delivery may contribute to increased stability (Berry, Forder, et al. 2004), in that fewer inequalities as a result of improved service delivery may reduce the chances that conflict will be sustained (Brown and Stewart, 2006; Vaux and Visman 2005). As Vaux and Visman (2005) put it:

*Delivery of services, such as health and education, can play an important role in preventing conflict or exacerbating it. Distribution of resources and their accessibility by or deliberate denial to different groups may either address or heighten existing social inequalities. Equity and inclusiveness are critical issues, as well as indicators, for those seeking to ensure service delivery promotes sustainable peace.*

This argumentation assumes the inequity and inequality are the main drivers of conflict, however, the causes of conflict are varied, and inequality is seen to be only one of many possible causes. Currently, there is no robust evidence to support the assertions that equitable service delivery can stabilize states, and much more research on this topic is needed.

*...the important issue becomes not so much that health programs should be implemented and how, but rather how can the health sector contribute to identifying and resolving the political, social, and even economic drivers of fragility within a given country* (Waldman 2006).

Despite the lack of evidence, some policy-makers are moving forward with using health services for state stabilization. For example, USAID in South Sudan has given higher priority to conflict resolution than to health equity in implementing its Fragile States Strategy (Waldman 2006). USAID decided to move its health program from the poor, very disadvantaged southern and western parts of South Sudan to the transitional areas, possibly contributing to greater inequity, arguing that it may contribute to increasing the probability of a lasting peace. If such an intervention succeeds in preventing the resumption of conflict, it may subsequently contribute to increasing health equity over time due to benefits of enhanced stability, such as economic growth and restoration of basic public services. How effective this strategy has been in state stabilization remains to be seen. In the meantime, the health of the populations in southern and western Sudan may have suffered as a result of this policy.
On the other hand, one can imagine instances where the objectives of health equity and conflict resolution coincide. This may be true, for example, of settings where fragility is a function of the marginalization of certain ethnic groups. Increasing health services to these groups might make a substantial contribution towards securing peace. For example, the acceptance of Hutu nurses back into Tutsi-run government services in Rwanda in 1996 was seen as an important stabilizing factor (Waldman 2006).

What can be concluded from the fragile states literature is that to address health inequalities in fragile states, agencies need to address state fragility over the long-term because it is very likely that underlying conditions, such as peace and a legitimate government, need to be in place before serious strides towards the development of an equitable health system can be made. Thus, while equity is a key goal of public health, any investments made in equity need to be supported by parallel investments in peace processes in order to reduce the high risk of a resumption of hostilities, as resumption will undermine any progress made towards health equity.

A good example of the sort of integrated approaches to addressing state fragility that are being promoted by donors is AusAID’s 2006 White Paper, that argues that effective engagement must be flexible, tailored to the context and be predicated on long term engagement:

> Assistance needs to be flexible to take advantage of windows of opportunity and respond to changing conditions, but the low capacity of fragile states and the extent of challenges facing them mean that assistance is likely to be needed over decades. The long-term vision for international engagement must be on state building through support for increased capacity, legitimacy and accountability and for an enabling environment for economic growth. Further, the interdependence of the political, security, economic and social spheres requires policy coherence within the administration of each international actor. (AusAID, 2006).

This approach is consistent with the OECD-DAC’s twelve ‘principles for good international engagement in fragile states’ (OECD-DAC 2005), which suggests that donors should engage more quickly, and for a longer period of time in fragile states. These principles also reflect those of the Good Humanitarian Donorship initiative, a donor initiative to improve aid harmonization, and which promises to give aid impartially, and according to need (Good Humanitarian Donorship Initiative 2003). It is interesting to note that the word equity is not mentioned in either document, perhaps because equity is seen to be inherent in the humanitarian principle of impartiality, where aid is given according to need without discrimination as to class, ethnicity, or political affiliation.³

The next few sections outline how to try to achieve equity in conflict-affected fragile states, ideally in tandem with peace efforts by the international community. As referred to in Figure 4, strategies to improve health equity can be categorised according to the ‘level’ of the health

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³ Impartiality is no discrimination as to nationality, race, religious beliefs, class or political opinions. Humanitarian agencies endeavour to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.
sector at which the intervention will be implemented. There are three categories of intervention: strengthening pro-equity policy and planning functions; building provider capacity to provide health services; and reducing access and participation barriers for excluded groups. Each strategy is described in more detail below. In general, post-conflict contexts provide more opportunities to work on health equity due to newly stable political contexts and increased security compared to settings with high levels of conflict. However, even in countries affected by on-going conflict there are opportunities to address equity issues.

5.1 Strengthening pro-equity policy making functions

A paper commissioned by the High-Level Forum on the Health MDGs made the following general recommendations regarding policy making:

*Place considerations of equity firmly at the top of the policy agenda. Providing health services to the people who have suffered most from protracted violence (such as women, the displaced, the disempowered) should be the overriding concern. Mapping the delivery of health services countrywide, so that both privileged and neglected areas can be identified, helps to direct providers towards comparatively underserved areas. The cost differentials involved in delivering services in areas that are operationally demanding need to be taken into account when budgeting new interventions. Donors should try to back their equity recommendations with adequate financing.* (High-Level Forum on the Health MDGs 2005b)

This raises a number of questions, however. What can be done in settings where there is limited political will to implement equity-oriented policy? What if there is the political will, but limited capacity for policy making? Is it possible for donors and international agencies to work around a government that lacks both willingness and capacity? And should equity always trump security as a policy focus?

**Finding Entry Points to Build Equity Oriented Political Will**

In many cases the, post-conflict period in particular may represent a unique opportunity for addressing issues related to health policy making:

*… post-conflict periods also provide opportunities to transform the values, policies, laws, service provision, human resources and inter-personal relations within healthcare systems as well as within every other sector of society and governance.* (Bloom 2005)

Another general point is that rebuilding effective health systems clearly creates conditions in which it becomes significantly easier to address health inequities via action within the health system. While a discussion about rebuilding health systems in post-conflict settings is beyond the scope of this paper, there is a significant literature on this topic that can provide guidance for anyone confronted with this task. Recent examples include “Health Service Delivery in Post-Conflict States” written for the High-Level Forum on the Health MDGs (High-Level Forum on the Health MDGs, 2005b), or Vaux and Visman’s DfID paper “Service Delivery in
Countries Emerging from Conflict” (Vaux and Visman 2005). Other useful papers include: (Zwi, Ugalde et al.; Macrae, Zwi et al. 1995; Macrae 1997; Balladelli 2000; CPHA and LSHTM 2000; Sondorp and Zwi 2002). Case studies include Nicaragua (Garfield 1989), Uganda (Okounzi and Macrae 1995; Macrae, Zwi et al. 1996), Ethiopia (Barnabas and Zwi 1997; Kloos 1998; Milas and Latif 2000), Cambodia (Lanjouw, Macrea et al. 1999), Kosovo (Davies 2000; De Ville de Goyet and Sondorp 2001; Shuey, Qosaj et al. 2003), Mozambique (Hanlon 1992; Noormahomed and Segall 1992; Pavignani and Durao 1999; Pavignani and Colombo 2001), Afghanistan (Bower 2002; Sharp, Burkle et al. 2002), Angola (Pavignani and Beesley 1999), Chad (Foltz and Foltz 1991), Palestine (Forsythe 1994), Former Yugoslav Republic of Macedonia (Manenti 2002), East Timor (Morris 2001; Van der Heijden and Thomas 2001; Tulloch 2002) and Angola, Liberia and Cambodia (Balladelli 2000). One of the most important findings is that in post-conflict countries, it is important to devise a national health policy framework at the beginning of the post-conflict process (Carlson, Lamalle et al. 2005).

Raising awareness of equity concerns early on during this health policy making process is important. However, there may be “pockets” of resistance to implementing equity oriented policies within certain central ministries or at certain levels of government (Berry, Forder et al. 2004). Brokering political commitment to equity is clearly important if equity concerns are to be placed high on the agenda. Political willingness to implement equity-oriented policies can be strengthened by demonstrating that equity-oriented interventions can contribute to conflict prevention and reduction. Some authors have also argued that it is important to actively solicit the input of previously excluded groups such as the poor and women, to ensure that their interests are considered in the nascent policy making process; this can be achieved via civil society groups, although it takes time to establish them in post conflict settings (Vaux and Visman 2005).

Donors may be able to promote equity concerns through various mechanisms. These include pre-existing resource mobilizing and planning tools such as the UN’s Common Humanitarian Action Plan and Consolidated Appeals Process, the United Nations Development Assistance Framework, and the pre-Poverty Reduction Strategy processes. More recent introductions also include the Transitional Results Matrix which have been piloted in Liberia, Central African Republic and Timor Leste.

The experience of the WHO in the former Yugoslav Republic of Macedonia may be instructive in that several approaches were taken towards building political will towards health equity. First, the WHO worked in partnership with national policy makers, as well as UNICEF and UNHCR to ensure that health (and other) services were not returned to the pre-conflict state of affairs. Rather, a new health policy was developed that safeguarded “equity, human rights and integration of vulnerable groups” (Manenti 2002). Second, WHO promoted changes through “demonstration programmes”:

_Innovative health policies against segregation and social exclusion were founded on a programme-based approach. The changes in policy were combined with concrete and visible activities at field level that documented the practical value of the proposed changes._ (Manenti 2002)
Third, WHO assumed the role of assisting public health workers in finding appropriate strategies and programmes to tackle the behaviours that encourage “social polarisation, discrimination, racism and violence” (Manenti 2002). Together, these interventions allowed the WHO to build political support for health equity amongst people involved in the health sector.

**Strengthening Capacity of State Policy Making Functions**

Where there is willingness to implement equity-oriented policies, it is important to direct efforts to build policy making capacity at the state and state structures. For example, technical support within the Ministry of Public Health (MoPH) has been integral to the expansion of contracting in Afghanistan (Palmer, Strong et al. 2006). Capacity for equity-oriented policy making can also be built through training programs. For example, in Afghanistan, the London School of Hygiene and Tropical Medicine (LSHTM) is running a year long, in-country public health training program for 28 top managers of the MoPH where issues of equity and efficiency are being highlighted in the modules on health systems planning, management and finance. This should strengthen senior policy maker’s understanding of some of the trade-offs around equity and efficiency, and allow them to make informed policy decisions given the context that they work in. An alternative approach, such as sending selected personnel to Masters of Public Health courses outside the country, is likely to have a significant negative impact on capacity, at least in the short term.

Monitoring linked to policy and programme adaptation is necessary to ensure that the implementation of policies is having the desired impact on equity (Carlson, Lamalle et al. 2005), and planning for such monitoring should begin at the outset (Delamalle, 2004). Data should allow for disaggregation and sub analysis on the basis of ethnicity, sex, displacement status etc. Without such information, it is very difficult to develop pro-equity programming. To this end, capacity-building should involve building systems for collecting and analysing the data necessary for planning the equitable distribution of services. For example, in Afghanistan, an inventory of existing health facilities was carried out in order to identify capacity gaps in the public and private health services’ ability to deliver the Basic Package of Health Services (Ickx 2002). This revealed high levels of inequity of distribution of health services between provinces and between districts within the same province. Ultimately this fed into an initiative to start the development of a decentralized health plan. Such rational planning techniques enhanced the credibility of the central MoPH with respect to the issues of equity and sustainability.

**Using Non-state Mechanisms for Policy Coordination**

Coordination between all actors is crucial in conflict affected environments, and has been identified as a key factor in determining the effectiveness of health sector interventions, in fragile state contexts, including their ability to reach the poor (Carlson, Lamalle et al. 2005). Harmonization between donors, and alignment of priorities between donors and national governments is key to pursuing equity as a policy goal.

Where capacity is so weak as to make a sector dysfunctional then it may be necessary for external actors to fulfil this function, although it is also important to involve indigenous or state
actors, and to initiate capacity building at an early stage; a failure to do so can severely hamper health sector rehabilitation and reform. For example, in Nepal, the World Bank formed the Nepal Rural Water Supply and Sanitation Fund Development Board in response to the perceived failure of the Nepalese Government to deliver sustainable services, and because the Bank felt that political interference in project selection was leading to distortions in coverage (Berry, Forder et al. 2004).

In countries where the UN is mandated to provide a transitional authority, coordination of approaches to equity between the UN transitional government, national government actors, donors and NGOs is crucial. A failure of such a body to engage effectively with the key stakeholders can be problematic. For example, in Cambodia, the United Nations Transitional Authority (UNTAC) was established “to address the constitutional vacuum which existed between the signing of the peace accords (in 1991) and the formation of the elected government.” (Lanjouw, Macrea et al. 1999). Equity was an explicit objective of UNTAC, as expressed in the Declaration for the Rehabilitation and Reconstruction of Cambodia:

_The primary objective of the reconstruction of Cambodia should be the advancement of the Cambodian nation and people, without discrimination or prejudice, and the full respect for human rights and the fundamental freedom for all... In the context of the reconstruction efforts economic aid should benefit all areas of Cambodia, especially the more disadvantaged, and reach all levels of society._ (Lanjouw, Macrea et al. 1999)

However, UNTAC worked outside of existing state structures, and failed to developed a cooperative and effective partnership with national and international actors who consistently worked outside of the UNTAC framework. As a result, UNTAC (and the Declaration) had little impact and its capacity to monitor and coordinate aid was significantly undermined. A more positive example can be found in East Timor, where the United Nations implemented an Interim Health Authority early on in the rebuilding process (Box 4), which played a central role in initiating health sector reform with equity as a primary objective.

**Box 4. Rebuilding the health system in East Timor**

From the time it gained independence from Portugal in 1975, East Timor suffered decades of chronic conflict until the withdrawal of Indonesian troops in September 1999. The announcement of the results from the referendum on independence resulted in a dramatic destruction of an estimated 70% of East Timor’s infrastructure. The impact of the violence on the health system was dramatic: over 35% of health facilities were destroyed (a further 40% were seriously damaged); most doctors and senior management staff left the country; and most medical equipment and supplies were looted or destroyed.

The rapid deployment of a multinational Peace Keeping Force with a robust mandate was crucial in re-establishing the security necessary to allow the subsequent rehabilitation the health system and other public services. Once peace and security had been established, services were initially provided primarily by NGOs; the Timorese health system no longer had the capacity to deliver services. Securing sufficient funding was a second crucial step – by June
2002, 500 million US$ in aid had reached the country. Equity, acceptance of cultural diversity, and accountability had already been accepted as core principles on which the health system should be based – as outlined in the Strategic Development Plan of East Timor that was developed in April 1999 in anticipation of independence.

The coordination role was undertaken initially by the UN (Alonso and Brugha 2006). To ensure longer term coordination of the rebuilding of the health system, as well as to build indigenous policy making and managerial capacity, an Interim Health Authority led by Timorese people (which can be viewed as a nascent MoH) was established very early on in the rebuilding process (Tulloch, Saadah et al. 2003). A crucial step to ensuring that this Interim Health Authority had real decision making power was to give it a voice in the allocation and disbursement of funding to the NGOs.

NGOs continued to provide the necessary capacity for service delivery, and became responsible for developing district level health plans. The plans had to comply with guidelines and standards developed by the Interim Health Authority which were predicated on ensuring maximum coverage for basic services and building local capacity (Tulloch, Saadah et al. 2003). As a result, the rehabilitation of the health system rationalized the pre-independence health system significantly in terms of decreasing the number of facilities and staff; this was seen to be necessary to ensure equitable provision of basic services (Alonso and Brugha 2006).

Finally, non-state mechanisms may also be used to coordinate (or advocate for) equitable policy related to specific disadvantaged groups. For example, UNHCR has recently been given the mandate, via the OCHA ‘cluster mechanism,’ of coordinating the provision of goods and services to IDPs. This is an important step in “preventing excess morbidity and mortality among IDPs and in providing them with the basic human rights and dignity now afforded to most refugees” (Salama, Spiegel et al. 2001).

5.2 Building Provider Capacity to Ensure Equitable Service Provision

Strategies aimed at building provider capacity clearly have the potential to contribute significantly to addressing health related inequalities in conflict-affected countries. While there is scant evidence on the impact of capacity building on health equity, logical argument would dictate that enhanced provider capacity can decrease access barriers for previously marginalised groups. For example appropriate expansion of capacity in previously underserved areas would address geographical access barriers, a significant driver of inequity in conflict affected environments. Capacity building could have an impact on differential exposure (e.g. via controlling epidemic outbreaks), differential vulnerabilities (e.g. via restoration of access to vaccination), and the differential consequences of ill health (e.g. via restoration of basic curative primary health services in rural areas).

In post-conflict countries, the aim should be to rapidly achieve good geographical coverage of essential services via the roll-out of a basic package of care. This should be prescribed by the government, and consist of essential services (maternal and child health care, communicable disease control, essential drugs) based on local burden of disease. Service delivery can be
through a variety of mechanisms, from public sector delivery to contracting. This is the embodiment of a rights-approach to health care, and has the principle of equity at its core. As such, delivery of a basic service of care should be key to post-conflict health service delivery.

In conflict settings, where humanitarian agencies provide temporary health services, maintaining and building on pre-existing local capacity should be objectives. A particular challenge is the plethora of national and external actors including UN agencies, multilateral and bilateral donors and a large number of NGOs with different competencies and resources, many of whom will be making some attempts to build capacity. Developing a framework for capacity building activities can be useful to coordinate activities.

**Building Government Capacity to Deliver Services**

Improving provider capacity can focus on enhancing government capacity to deliver services. There is a wide literature on building the health service implementation capacity of government officials (Carlson, Lamalle et al. 2005; Vaux and Visman 2005). In settings with high levels of conflict, the humanitarian actors have a role to play in maintaining existing capacity, which can subsequently reap dividends when attempts to strengthen capacity accelerate in the post conflict period. For example, Sibbons (2004) has documented how support given to the education system allowed at least a minimum service to be maintained in those areas of the north and east of Sri Lanka where the conflict was relatively low-level. As a result, there was sufficient capacity in those areas to rapidly scale up the scope of services during the transition to peace. Similarly, Vaux and Visman concluded:

*Health staff trained in emergency humanitarian assistance programmes in Mozambique strengthened national capacity to restore services after the peace agreements. Similarly, health staff trained in refugee camps in the Thai/Cambodia border proved a valuable asset in the reconstruction of Cambodia’s health sector,...* (Vaux and Visman 2005)

Several of our key informants made similar observations about the role of humanitarian NGOs in strengthening capacity within Afghanistan – it may be one of the factors facilitating the relative rapid development of indigenous NGO capacity in the health sector. Dijkzeul (2005) reviewed the approach of five NGOs working in the DRC to draw conclusions about the importance of capacity building to service delivery in difficult environments. While he did not consider equity *per se*, he concluded that the programmes gave improved access for vulnerable groups that had previously been unable to access service, and built more sustainable service delivery by local organisations (Dijkzeul and Lynch 2005). He went on to draw some lessons about how to manage the process of capacity building. In the initial stages, he concluded that capacity building requires close managerial supervision, and an ability to negotiate a consensus on roles and responsibilities with local partners. He observed that capacity building was required at all levels of the health system, and that donors were able to leverage significant influence over the capacity building elements of programmes, which may have helped ensure standardisation of approaches, comparable standards and levels of achievement.
Integral to building the capacity of government providers is the importance of the maintaining the salaries of government workers. Macrae (1995) found that based on the Ethiopian experience:

A key factor enabling staff to remain in post was that they continued to be paid. While this is explained in part by the fact that key bureaucratic institutions, including payroll departments continued to function in large parts of the country, also important is that resources were made available to pay them. As salaries were fixed above subsistence levels, the incentives to staff to work privately were reduced. In the immediate `post'-conflict period, considerable attention should be placed on strategies to maintain salaries for public health workers. (Macrae 1995)

A number of key informants also cited remuneration as a key component of building government capacity, and added that additional financial incentives are important tools for addressing inequities in the distribution of the health work force. Other strategies mentioned included the provision of non financial incentives (such as training and supervision), as well as standardising pay scales at a national level to overcome the impact of large salary differentials on the distribution of human resources. Examples given of this last phenomena included situations where NGO salaries are significantly higher than salaries within government run health services. As a result, NGOs are able to attract and retain the best staff; large vertical programmes, such as the Global Fund for HIV/Aids, tuberculosis and malaria (GFATM), also tend to draw staff away from government posts.

Van Damme and Van Leemput et al (2004) make the point that no matter what other strategies are employed towards providing equitable access to health care, strengthening of the public health system is key:

…it is only in the presence of a quality public health system, that other strategies – such as improved regulation of the private sector, demand-side interventions, safety nets for the poor, pre-payment systems or social health insurance – can yield good results. In fact, a combination of various strategies is needed to give people access to quality health care, and to prevent people from falling into poverty through out-of-pocket payments for health care. (Van Damme, Van Leemput et al. 2004)

Harnessing NGOs as Non-state Providers

Capacity building can also occur via the contracting of non-governmental organisations (NGOs) to deliver health services. Contracts with NGOs to deliver health services are increasingly being promoted in post-conflict fragile states as an effective way to expand services quickly, and to reach many of the poorest people living in these countries.

A contracting experiment done in Cambodia between 1999 and 2003 (Box 5), stimulated interest in contracting. This study found that when contractors (who were mostly international NGOs) entered into contractual obligations to equitably provide health services, contractors were better than the government at reducing inequities (Bhushan, Keller et al. 2002; Bhushan, Bloom et al. 2005; Loevinsohn and Harding 2005). Based in part on the success of contracting
in Cambodia, contracting is now being employed on a wide-scale in Afghanistan, and will be implemented in DRC and South Sudan.

Contracting in Afghanistan has been done at a national scale since 2002. In collaboration with the MoPH, the World Bank, the European Union and the US Agency for International Development (USAID) have funded contracts with NGOs worth over $140m (£80m; €118m). This inflow of substantial resources combined with contracts for service delivery has allowed for the expansion of services to 77% of Afghanistan (i.e. 77% of the population lives in areas where the services are provided). International NGOs tended to be awarded contracts in the first few years. However, there has been a remarkable increase in the number and size of local NGOs, and they are increasingly competing with international NGOs for service delivery contracts (Palmer, Strong et al. 2006).

**Box 5. Contracting in Cambodia**

Contracting NGOs to manage the primary health care system was found to be an effective means to increase service coverage and achieve a more pro-poor distribution of services in rural areas of Cambodia (Bhushan, Keller et al. 2002; Bhushan, Bloom et al. 2005; Loevinsohn and Harding 2005). In the mid-1990s, war and political upheaval had left Cambodia with limited health care infrastructure, especially in rural areas. To address this, the Ministry of Health (MOH) proposed contracting NGOs to manage at the district level of the public health care system using a results-based contract to monitor progress.

A five-year contracting experiment started at the beginning of 1999 and a final evaluation survey was taken at the end of 2003. An equity goal to target services to the poorest one-half of the population was mandated for all of the districts. There were three contracted-in (government management contracts), two contracted-out (NGO service contracts), and four control districts.

The results from this study showed that contractors were considerably better than the government at reducing inequities. Use of curative health services at district hospitals by the bottom half of the socioeconomic group increased about twelve fold in contracted-out districts and six fold in contracted-in districts in 2½ years. The corresponding increase in the control districts was considerably less than double. In addition, private out-of-pocket health care expenditures in contracted districts were lower than government districts, which clearly benefits those who can least afford to pay. NGOs appear to be more responsive to contractual obligations to effectively and equitably provide health care services than standard government provision of services given the same goals.

In conflict settings, the most feasible way of delivering any services in conflict-affected fragile states is via direct service provision by humanitarian NGOs. For example, the evaluation of ECHO funded activities in south Sudan between 1999 and 2002 concluded that continued humanitarian assistance was the only way that the conflict-affected population would be able to get any access to services (Shuftan, van der Veen et al. 2003).
Most humanitarian agencies are signatories to the Red Cross Code of Conduct (Red Cross 1994). This document outlines the key humanitarian principle of impartiality, which is implicitly equity focused:

\[
\text{Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone... Aid will not be used to further a particular political or religious standpoint. (Red Cross 1994)}
\]

Furthermore, the Sphere Project’s \textit{Humanitarian Charter and Minimum Standards in Disaster Response} (The Sphere Project 2004), which contain explicit equity objectives, is becoming the standard for both humanitarian programming and the evaluation of humanitarian action. Humanitarian NGOs thus consider equity issues when they are carrying out humanitarian programming in that they aim to be inclusive and accessible to all irrespective of social status (gender, political loyalties, ethnicity, etc). However, the humanitarian conceptualization of equity is slightly different from that found in the development literature, in that equity is about bringing a targeted vulnerable population up to a minimum standard of care. This can result in ‘islands of privilege’ as mentioned previously, which can be seen as inequitable as people outside the ‘islands of privilege’ area may not be able to access adequate services (this is often due to security constraints and/or insufficient resources to provide services to all that need them). Humanitarian agencies tend to view these ‘islands’ as foundations on which to build upon, and as an example of between-country equity in terms of provision of services similar to other comparable regions of the world.

\subsection*{5.3 Addressing reduced access and participation barriers for excluded groups}

Poor people lack access to services in difficult environments for a number of reasons. These include deliberate social exclusion (on the basis of gender, ethnicity, religion, caste, tribe, race, or political affiliation), remote geography, inappropriate services, high real and/or opportunity costs, or security concerns. Demand-side strategies to address access include increasing demand for services, addressing geographical access barriers by improving coverage, and reducing financial barriers to access in the form of formal user fees.

\textit{Community-based Approaches \& Addressing Non-financial Demand Side Barriers}

Community-based approaches can be used to address non-financial, demand side barriers to health service delivery. While there is a long history of community-based approaches in the development field, there is much less experience with it in the humanitarian field (Commission on Human Security 2003). Slaymaker \textit{et al} (2005) document the use of community-based approaches to service delivery in difficult environments. They argue that such approaches have the potential to be more responsive to the needs of beneficiaries, but that they need to be complemented and guided by an overarching framework that defines standards to ensure quality and equity in the provision of services (Slaymaker, Christiansen \textit{et al}. 2005).

The impact of such interventions on health equity in post-conflict environment is not well evaluated in most cases. An example from Sudan suggests that community-based approaches
Promoting Health Equity in Conflict-affected Fragile States

could have an impact on health equity, however. The evaluation of the Child-Friendly Community Initiative in Sudan, which was a community-driven multi-sectoral approach for increasing the access of poor and vulnerable people in a conflict-affected area of southern Sudan, concluded that such an approach can be relatively successful at building capacity at both the community and local government levels. The report also highlighted that such initiatives can be very useful for addressing non-financial demand side barriers for services through education and community mobilization (Moreno-Torres 2005).

Involving marginalised and excluded groups in decision-making processes may also be a useful strategy, although establishing the necessary civil society institutions to facilitate this takes time:

The establishment of such bodies and channels for engagement of the poor in decisions, which directly affect them, takes time, particularly during times when people are most concerned in meeting their immediate needs. This is particularly the case for women, who usually have prime responsibility for child care and the strongest interest in delivery of services … (Vaux and Visman 2005)

Strengthening the voice of the vulnerable through community-participation and democratization could be used to address differentials in exposure, equity or consequences of disease. Community involvement should also assist in designing and implementing strategies to target locally relevant drivers of health inequity. The other interventions – moving resources to the community level, facilitating physical access to providers and reducing the cost of accessing services – seem to be used largely for reducing differential access to hospital/curative care (i.e. differential consequences of disease).

**Reducing Geographical Access Barriers**

In conflict settings, humanitarian agencies can address geographical inequities in service delivery within the constraints imposed by security considerations. Even governments dealing with a significant level of internal conflict can choose to support equity. For example, in Sri Lanka, the Government maintained a strong commitment to equity of access for basic services and continued to support services in Tamil Tiger held areas; basic health indicators have thus remained fairly comparable between government and Tamil Tiger controlled areas.

In post-conflict settings, many of the efforts to improve geographical coverage of health services, alongside investments in transport infrastructure and provision of enhanced security, are all required to minimise geographical access barriers; most of the action on this front is dependant on national level actors. However, it would seem sensible to also develop strategies to address these issues locally. To date there is little documented in the literature in terms of interventions at this level. Berry, Forder et al. (2004) highlight the importance of assuring the safety of the community (and providers) in accessing health care services. In conflict settings, this may involve local actors, especially NGOs and longer-term indigenous civil society actors, invoking humanitarian law and seeking to get monitoring missions on the ground to hold state and non-state forces accountable for their actions, for example as is happening in Darfur. The humanitarian community, including some medical NGOs such as Médecins Sans Frontières, takes part in témoignage, or witnessing of human rights violations in many of its missions. They
argue that their presence (besides provision of services) assists indirectly in enhancing access to health care by enhancing security and increasing the prominence of human rights issues on policy agendas.

**Addressing Financial Access Barriers at the Community Level**

In conflict and post-conflict settings, user-fees are the most common form of health financing. However, as described earlier in the paper, they are a very regressive form of financing (the poor spend proportionately more of their income on health care), they create significant access barriers, raise limited revenue in resource poor environments and can tip individuals and families into poverty. As a result, the humanitarian community have been advocating strongly against user fees, which they feel are inappropriately imposed on already vulnerable populations by donors, and governments. There does seem to be a shift in donor thinking, with many in DfID now actively discouraging the imposition of user fees in fragile states. However other donors, such as ECHO, the EC and USAID still advocate for them on sustainability and efficiency grounds, as well as the belief that there is no other alternative.

This paper takes the position that services should be provided freely in humanitarian settings for equity reasons. In post-conflict countries, services should also be provided freely, with the caveat that donors or national governments must ensure that more money is provided to the health system to allow the system to cope with the increased demand, and that mechanisms are created to channel funding down to the health centre level (Gilson and McIntyre 2005).

However, while avoiding user-fees minimises financial access barriers, user-fees continue to be implemented because governments see no alternative in the absence of sustained donor commitment to provide long-term funding. As a result, one challenge for the poor is meeting the cost of accessing services, both direct and indirect. While there may be a willingness to purchase/access health care services, there may not be the ability to pay, particularly among the poorest, hence the need for some kind of social fund, umbrella grant, or dedicated government funding mechanism to which communities can direct proposals for project funding. Community health financing (health equity funds or community-based health insurance) may be an option in a few post-conflict settings (as in post-conflict Rwanda), however the evidence base remains extremely limited. In addition, it is important to note that initiatives based on solidarity or sense of community may be quite difficult to promote in conflict affected areas:

...pre-payment schemes or social health insurance systems are undoubtedly the best long-term solutions for protecting health and welfare of the citizens of a nation (Kawabata et al. 2002). However, in a country like Cambodia, where mutual trust between citizens has been profoundly undermined, and where trust in the public system is very poor, such solutions may take many years to develop. Moreover, the poorest are often the last to participate in any such risk-sharing systems. (Van Damme, Van Leemput et al. 2004)

More recently, there have been a few examples of attempt to address poverty as a social determinant of health in conflict affected countries via the introduction of cash-transfers, or to use cash transfers as a tool for facilitating peace building via disarmament, demobilisation and
reintegration programmes. For example in 2004, Action Contre la Faim implemented cash for work programmes in southern Somalia. Based on this experience, they have concluded that such cash-based interventions are a feasible option in conflict affected environments, and that they can be a powerful tool to empower previously excluded groups to meet their own needs (such as health care) in a timely manner (Mattinen and Ogden 2006). Willibald (2006) has argued, while acknowledging the limited availability of empirical data, that there are strong theoretical argument why cash transfers might be useful in difficult environments. She concluded that there is a need for a more detailed examination of the potential of cash transfers (in comparison to other forms of aid) that would allow for assessment of the contexts where cash transfers might be useful.

6. DISCUSSION AND CONCLUSIONS

Equity concerns may contribute to (or be the cause of) a particular conflict, and some commentators argue that conflict may sometimes be necessary for ensuring that inequities are addressed in the longer-term. However, whatever the cause of conflict, all wars invariably have an enormous impact on health equity due to the impact of the war on the economy and people’s livelihoods. This increases the equity gap between the war-affected country and other countries of similar socio-economic development. In some cases, equity within a conflict-affected country may actually be improved because of a levelling down effect as everyone becomes worse off in comparison to pre-conflict baselines and non-conflict affected countries. However in other conflicts, the intensity of fighting varies between regions resulting in differential impacts by geographic area. As a result, some subpopulations suffer dramatic declines in health, and there is an increasing equity gap, both within the country, and in comparison with other countries.

The health impacts on populations that are severely conflict affected are often catastrophic and humanitarians argue that they should be provided with a minimum standard of care, even if this result in these populations having access to better care and eventually better health status relative to other populations. They would argue that the equity concerns that these ‘islands of privilege’ raise should be addressed not by levelling down the quality of care (and enjoyment of reasonable access to other key SDH), but rather they should addressed by levelling up. These ‘islands of privilege’ should probably not be seen as ‘islands of inequity’ but rather as ‘islands of hope’ because they demonstrate what can be achieved in conflict affected environments if sufficient resources are mobilised and used effectively.

6.1 Concerns with health equity as a primary goal

Sadly, despite intense recent interest in the fields of health equity and health in fragile and conflict-affected states, there is a lack of empirical evidence about the impact of conflict on health equity, and what strategies can be effective at addressing health inequity in such environments. There is also concern about the potential for misguided interventions to do harm:
Development projects and policies operate in such arenas, where power relations are constantly being (re)negotiated. They are a political resource: development activities (whether they involve building schools or infrastructure, providing micro-credit, supporting the formation of women’s groups, etc.) constitute external injections of resources and rules systems that legitimize particular actions and discourses and thus strengthen particular individuals, groups or ideas at the expense of others... They are thus likely to impact—positively or negatively—on conflict dynamics. (Barron, Diprose et al. 2006)

Governments and donors should proceed cautiously when consideration is being given to developing and implementing strategies to optimize health equity in conflict-affected fragile states. Efforts to address health equity, if they are badly designed and implemented, have the potential to exacerbate conflict, and undermine the longer term development of health systems.

A strong case can be made that addressing state fragility and conflict prevention is necessary before any impact can be made on health equity. Where the principal causes of morbidity and mortality (and health inequity) are ongoing conflict, it may be most cost-effective – in terms of achieving health equity – to invest in conflict resolution.(Waldman 2006) If the principal objective is to improve the population’s health, health service delivery should be supported by programs that aim to contribute to the consolidation of an ongoing peace process. In the meantime, more research needs to be done to as answer such questions as:

- Can health programming reduce the chances of conflict re-occurring?
- Does reducing inequity reduce the chances of conflict re-occurring?
- Can targeting certain areas with health programming help consolidate peace?

In the absence of any robust answers, there is a need for careful analysis of a specific context when making decisions, and a preparedness to experiment and adapt in light of success or failure. There is also a need for much more research on the dynamics between (equitable) service delivery and state stability.

Finally, as in non-conflict-affected states, there will be a trade-off between equity and efficiency. A focus on the health equity goals of humanitarian programs – which are biased towards addressing inter-country inequities via the application of normative best-practice standards such as the Sphere guidelines – can compromise the objective of improving the overall (i.e. “average”) health of the entire population. In the post conflict period, trade-offs may have to be made between geographical scope of coverage and the scope of services that are made available (Afghanistan provides an example of this). In the interests of within-country equity, a decision may be made to level down as levelling up the standards of the ‘islands of privilege’ may not be feasible. Such a decision inevitably requires a trade-off to be made between equity and efficiency as it is more expensive to extend a similar level of service to sparsely populated and geographically isolated areas. There are also concerns that while such an approach is equitable, if it entails delivering an affordable but limited package of care that does not address the major local causes of morbidity and mortality, it will not have a significant impact on health outcomes overall.
6.2 Emerging lessons and recommendations

Government and donors should pursue health equity as an objective. There are a variety of strategies that may prove useful. These strategies were categorized according to the level of the health system at which the interventions are targeted: policy-makers, health care providers or communities. An important first point is that the strategies identified in the published and grey literature are aimed predominantly at “downstream” inequities, i.e. differential consequences of disease. That is, the bulk of the strategies aim to reduce inequities in access to curative health care services. This finding will in part be a consequence of historic epidemiologic consensus on the health impacts of conflict; conflict results in high excess mortality, most of it due to treatable causes, and as a result the focus of humanitarian aid has a curative bias. It may also reflect the fact that international donors are more likely to be involved in financing the delivery of curative care (interventions that address differential exposure and vulnerability) and as a result these interventions are more likely to have been documented. Second, interventions at the level of policy makers and the community (interventions to address provider capacity) appear to be more likely to address “upstream” social determinants of health, such as differential exposure and vulnerability. But they also appear to be less carefully monitored, evaluated and documented. Regardless of the type of strategy, the impact on health inequities is rarely reported in the literature; claims that interventions promote equity tend to be based on outputs (such as the proportion of the population immunised against measles) or intermediate outcomes (such as increases in utilisation rates) rather than on changes in the distribution of morbidity and mortality.

Assuming that equity is prioritized by the key policy-actors in various conflict and post-conflict settings, we can conclude that:

1. Having established health equity as a goal, actors (national and local government, health care providers, community-members, donors) must work together towards developing a consensus on what the most important health inequities are, and what the priorities should be for intervention.
2. More can be done about health equity in post-conflict settings than in conflict settings. In post-conflict settings, universal coverage should be a concern. In conflict settings, efforts should be made to be as equitable as possible, within existing security, resource and political constraints.
3. In post-conflict settings, as soon as security, political and legitimacy considerations allow, an overarching health policy framework needs to be developed that explicitly includes equity as a primary objective. This requires that donors, INGOs, NGOs, government, and civil society stakeholders negotiate a clear, actionable and monitorable policy agenda that includes strategies for health system strengthening, health status improvement, and health equity improvement.
4. Coordination of the disparate actors is important both in terms of effective policy development, and also in terms of implementation. Where coordinating authorities control financial flows, this enhances their power to effectively coordinate other actors.
5. Adequate data collection and intelligent analysis to understand the context and describe inequities needs to be carried out to inform pro-equity decision making.
Promoting Health Equity in Conflict-affected Fragile States

Equity focused monitoring and evaluation are needed for accountability and programmatic adaptation.

6. The most vulnerable groups as a result of prolonged conflict are likely to be from social strata that can be defined in terms of sex, displacement status, socio-economic status, and geographically defined sub-populations, as well as specific populations that have been targeted during the conflict.

7. Geographical and financial barriers to accessing care are major drivers of inequity, and must be addressed.

8. Humanitarian aid and post-conflict reconstruction can be inequitable (for example, rehabilitation of urban tertiary care), or may be perceived as inequitable. Consider the equity implications of any interventions, and avoid doing harm.

9. It is important to identify and address health equity issues that pre-existed the conflict, and that were a result of pre-conflict failures within the health system. Post-conflict reconstruction offers the opportunity to build better, more-equitable system than existed previously. Re-building the previous health system to look exactly as it did before the conflict may restore pre-existing health inequalities.

10. Equitable health outcomes, and addressing differential exposure in particular, requires work across sectors. For example, as long as clean water, sanitation, and adequate nutrition are inequitably distributed, health outcomes will be inequitable. Health system actors must not act in isolation.

11. During, and immediately post-conflict, there will be a tendency to focus on picking the “low lying health equity fruit”. This might take the form, for example, of providing targeted services to disadvantaged populations, like refugees. Post-conflict health sector reconstruction plans need to have a “twin track” – they need to address immediate needs, as well as address longer term issues. Plans should also be made for strategies that have a longer-term horizon, such as: training of practitioners and other health personnel to staff rural facilities as they are rehabilitated; building health policy making capacity; and promoting community-based initiatives.

12. In setting priorities and developing interventions, pay attention to involvement of diverse elements of civil society.

13. If possible, plan strategies that explicitly enhance the legitimacy (first) and effectiveness (later) of government and reduce the risk of conflict recidivism.

14. At an international level, ongoing work to address inequities in aid flows should continue.

15. Ongoing reform of the international humanitarian and legal architecture will have a role in providing increased protection for vulnerable groups e.g. addressing the lack of protection for IDPs via establishing an international agency with a mandate to provide for them.

To conclude, the study of equity in conflict-affected fragile states is in its infancy. There are large gaps in the literature regarding quantitative and qualitative evidence of health inequity in conflict-affected fragile states, the effects of conflict on health equity, and strategies on how to rebuild health systems with equity concerns in mind. We are especially short of information on health equity strategies that can be implemented during (as opposed to post-) conflict. For ethical, logistical and security reasons, most research has been done in relatively stable post-conflict settings, and as a result such findings may not be applicable to less stable settings. As a
result, this paper makes conceptual arguments about the likely impact of conflict on health equity, and how health equity may be addressed during and post-conflict. Further research and analysis is clearly required if we are to become better at developing and implementing pro-equity programmes in conflict-affected fragile states.

Despite these limitations, this paper has made an initial attempt to draw out some of the issues, and created a model to explore the dynamics of how to address different types of equity in conflict-affected states. It highlights some of the tensions that may occur when applying an equity lens to conflict-affected states, however it concludes that equity is an important issue that deserves more discussion amongst the humanitarian community and those who work in post-conflict settings. Promoting health equity should be one of the guiding principles of health sector redevelopment in conflict-affected fragile states.
### Appendix 1. List of Fragile States Based on the World Bank's CPIA ratings*

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<td>N/A</td>
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8. REFERENCES


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