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health systems

research findings for development policymakers and practitioners

Rebuilding health systems after conflict

In the late twentieth century, 15 of the 20 poorest countries in the world experienced armed conflict. This has had devastating social and economic impacts on public health. Relief efforts provide short-term help but how do countries rebuild their health systems in the long term?

Researchers from the United Nations University World Institute for Development Economics Research (UNU-WIDER) analysed different countries affected by conflict, including Afghanistan, Cambodia, East Timor, Kosovo, Uganda and Mozambique. They looked at the impacts of conflict on public health, presenting a framework for understanding how health system rehabilitation programmes might work in post-conflict countries.

They found that in addition to death and ill-health caused directly by conflict, there were a number of indirect impacts. These included landmine injuries and emotional trauma, both often leading to permanent disability. Displaced populations were also a problem, with increased vulnerability to communicable diseases such as HIV, malaria, measles, diarrhoea and respiratory infections including tuberculosis. Further impacts on the health system itself included:

- a lack of disease surveillance resulting in inadequate information for setting priorities
- limited financial resources due to increased military spending, reduced government revenue, and greater dependence on aid
- severe shortages of health care staff
- a lack of qualified managers
- destruction of essential supplies, equipment, and infrastructure
- interrupted basic health services, with primary care suffering the most
- loss of political authority and legitimacy, made worse by the departure of academics and policymakers, leading to a breakdown in trust and social networks.

The authors suggest three interrelated approaches to health sector rehabilitation: an initial response to immediate health needs (through humanitarian assistance and relief); restoration or establishment of a package of essential health services including immunisation and obstetric care; and restoration of the health system itself.

The authors highlight the lack of co-ordination between donors, whose competing needs and projects distract health officials. NGOs may also delay progress, continuing to focus on relief after the country has moved to the next stage. Recommendations include:

- focus on strong management and financial structures to ensure sustainability
- strengthen information systems
- attract qualified staff to the public sector, including through compensation for hardship or danger
- make the most of external assistance, starting with modest aid and then increasing it in line with the country's ability to use it effectively
- form partnerships with NGOs
- ensure political commitment by government, including a clear national strategy for health systems development and long-term priorities, and co-ordination of donor activities and funding
- ensure short-term relief and assistance works alongside medium to long-term rebuilding of the health system.

Hugh Waters
Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, Baltimore, Maryland 21205, USA
T +1 410 955 3879 **F** + 1 410 614 1419
hwaters@jhsph.edu

'Rehabilitating Health Systems in Post-Conflict Situations', *UNU-WIDER Research Paper*, by Hugh Waters, et al, 2007

Promoting enrolment in community health insurance in Burkina Faso

Community health insurance (CHI) schemes often collapse because of low enrolment. What factors encourage households to join such schemes? Researchers from the University of Heidelberg in Germany looked at enrolment to CHI in Nouna Health District in Burkina Faso.

In countries with a limited ability to develop and sustain national health insurance programmes, CHI could be a valuable alternative to user fees. By pooling risks and resources at community level, it offers better access to health services and greater protection against the costs of illness for excluded and disadvantaged people. But CHI schemes in sub-Saharan Africa rarely reach ten percent coverage of target groups.

The Nouna scheme charges a yearly premium of 1,500 CFA francs (US$3) per adult and 500 CFA francs (US$1) per child. The package includes a wide range of first- and second-line services at health facilities within the district. The researchers studied all 154 enrolled households and a random sample of 393 non-enrolled households in the 15 eligible communities.

The study found that enrolment is unrelated to the sex and age of the household head, household health status, prior use of health services, or involvement in other risk-sharing arrangements. However, there is a link between enrolment and the following factors:

- Bwaba ethnicity
- better standard of education
- higher socioeconomic status
- poor perception of traditional health care
- a greater proportion of household members being children
- greater distance from the health facility
- lower socioeconomic level within the community.

This study suggests that the decision to enrol in CHI is shaped by a combination of factors related to the household head, the household and the community. The researchers caution that CHI schemes in sub-Saharan Africa may reinforce existing inequalities in access, due to differences in educational and socioeconomic background. To maximise enrolment and avoid enhancing inequalities, policymakers should:

- offer different premiums according to age to overcome prioritisation of adult above child health care
- conduct research into perceptions of illness and causes of disease, which influence health care choices
- include emergency transport in the benefit package, to prevent distance acting as a barrier to enrolment
- give members more freedom of choice in first-line provider
- use social marketing to promote increased risk-sharing
- tackle barriers to enrolment at decision-maker, household and community level.

Manuela de Allegri
Department of Tropical Hygiene and Public Health, University of Heidelberg, INF 324, 69120 Heidelberg, Germany **T** +49 6221 56 4682
manuela.de.allegri@urz.uni-heidelberg.de

'Understanding Enrolment in Community Health Insurance in Sub-Saharan Africa: A Population-Based Case-Control Study in Rural Burkina Faso', *Bulletin of the World Health Organisation*, 84(11), pages 852-858, by Manuela de Allegri, et al, 2006

Impact of joined-up programmes on HIV-related TB deaths in Estonia

The control of drug sensitive tuberculosis (DSTB), multi-drug resistant TB (MDRTB), and HIV is a serious public health challenge in Eastern Europe and Central Asia. Estonia has a rising HIV epidemic and a high prevalence of MDRTB. What effect will simultaneous TB control and HIV harm reduction programmes have in Estonia?

Estonia is experiencing a rapidly escalating HIV epidemic among injecting drug users (IDUs), with the highest rate of new HIV cases among former Soviet Union states. TB cases have also increased substantially and in 1998, Estonia's MDRTB rate was among the highest in the world. Poor MDRTB control is of concern in areas where there is a rising HIV infection rate. HIV is a major risk factor for latent infection developing into active TB.

A study was conducted by Imperial College London, Hertfordshire University's Business School, the London School of Hygiene and Tropical Medicine in the UK and the World Health Organization. It examined the impact of joined-up HIV harm reduction and MDRTB control programmes in Estonia. Harm reduction programmes reduce needle sharing and injection frequency among IDUs. The study explored the potential impact of different policy decisions on cumulative HIV and AIDS, TB, and HIV related TB deaths.

The study made the following findings:

- If effective harm-reduction programmes are in place, HIV-related deaths will drop by an estimated 30 percent, but will double if they are ineffective.
- Effective MDRTB and HIV control will result in a 54 percent drop in TB deaths, while MDRTB deaths will reduce fifteen-fold and HIV-related TB deaths two-fold.
- Effective MDRTB control alone will reduce TB deaths by only 22 percent.
- An effective harm-reduction programme run alongside a poor MDRTB control programme will reduce TB deaths by 34 percent, MDRTB deaths by 14 percent and HIV-related TB deaths by 56 percent.
- If harm reduction and MDRTB control programmes are neglected but drug sensitive TB is controlled well, there will be 50 percent more TB-related deaths than if all are addressed effectively.
- Deaths from TB are reduced more substantially by effective harm reduction programmes than effective MDRTB control.

If the emerging HIV and MDRTB epidemics are to be addressed effectively in countries such as Estonia, communicable disease policies must be changed substantially. The study recommends the following:

- Where there is high MDRTB prevalence and an immature HIV epidemic among IDUs, effective HIV harm reduction and DSTB/MDRTB control programmes must be set up simultaneously to prevent large numbers of deaths.
- In the early stages of an IDU-centred HIV epidemic, if too little attention is given to effective harm reduction, substantial deaths will occur even if good TB control is in place.
- A highly effective MDRTB treatment programme will have far less impact on cumulative TB-related deaths than if an effective HIV harm-reduction programme is in place.
- Continuing and improving harm-reduction programmes is critical for reducing cumulative HIV-related TB deaths.

Rifat A Atun
Centre for Health Management, Tanaka Business School, Imperial College London, South Kensington Campus, London, SW7 2AZ, UK
T +44 (0) 207 5949160 **F** +44 (0) 207 5945915
r.atun@imperial.ac.uk

'Impact of Joined-Up HIV Harm Reduction and Multidrug Resistant Tuberculosis Control Programmes in Estonia: System Dynamics Simulation Model', *Health Policy*, 81, pages 207-217, by Rifat Atun, et al, 2007

Rebuilding health services in post-Taliban Afghanistan

Afghanistan's health services were left in chaos after years of conflict. Neither the public nor private sectors could function effectively. There was a severe shortage of health staff, and infrastructure was grossly inadequate. What progress has been made in the past five years to reinstate effective health service delivery?

Across the country, health services were either destroyed or severely damaged. The ratio of basic health centres to population ranged from 1 in 40,000 in central Afghanistan to 1 in 200,000 in the south. Health staff were in short supply and health care was provided mainly by non-governmental organisations (NGOs). The level and quality of health care varied widely and a clearly defined health policy was absent.

In 2002, the Ministry of Public Health (MoPH) and major donors developed the Basic Package of Health Services (BPHS), providing guidelines for the reconstruction of infrastructure and staffing. Both the government and NGOs agreed to adopt a public-private design for service delivery, with the MoPH commissioning and directing services, and private NGOs delivering them.

A briefing paper from the Afghanistan Research and Evaluation Unit explores the challenges and identifies steps to help the health sector develop into a respected branch of government. It reports that the MoPH has made substantial progress in making the BPHS accessible to most people. The paper includes the following findings:

- There have been significant improvements in quality of care from 2004 to 2005, and 2005 to 2006. The number of outpatient visits, antenatal care and TB case detection rates have increased substantially.
- A newly established Grants and Contracts Management Unit has enabled the MoPH to improve contract management, a critical component of its collaborations with major donors and NGOs.
- Health sector funding is at a reasonable level, yet the country is likely to remain highly reliant on foreign funding for many years.
- Contracting for service delivery with NGOs and with three MoPH Strengthening Mechanism provinces has been successful.
- Competition for contracts has been strong, with a significant proportion awarded to Afghan NGOs set up after 2001.

If the MoPH can maintain progress in the health sector, it will make a substantial contribution to stabilising the country's political situation.

The study recommends that:

- The Ministry should develop a good communications strategy to ensure the public and officials are aware of the sector's achievements to date.
- Donors should ensure ongoing and predictable funding for the health sector.
- The Ministry and its partners must work to strengthen the Provincial Health Offices' management capacity so they are able to execute their responsibilities for managing public health.
- The Ministry should improve contracting systems by taking the best characteristics from all of the contracting mechanisms.

Ronald Waldman
Program on Forced Migration and Health, Mailman School of Public Health, Columbia University, 60 Haven Ave. B-4, New York, NY 10032, USA
T +1 202 460 2341
rw178@columbia.edu

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Send us your comments and feedback via SMS
+44 7504 882535

id21
Institute of Development Studies
University of Sussex
Brighton, BN1 9RE UK

T +44 (0) 1273 678787
F +44 (0) 1273 877335
E id21@ids.ac.uk

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