

IDS PRACTICE PAPER IN BRIEF

PRACTICE PAPER IN BRIEF 18
FEBRUARY 2015

Strengthening Health Systems for Resilience

In countries with high levels of poverty or instability and with poor health system management and governance, people are highly vulnerable to shocks associated with ill health, including major epidemics. An effective health system can help build their resilience by reducing exposure to infection and minimising the impact of sickness on livelihoods and economic development. There is broad consensus on the key elements of such a health system: measures to protect public health, access to safe and effective basic health services, hospital back-up and a capacity to respond to major health shocks. The creation of such systems requires sustained efforts to strengthen state oversight of the health sector and to build effective partnerships for public health and service delivery. Managing the crisis response should include anticipating the need to build effective, trusted health systems that meet priority needs.

A population vulnerable to health shocks

The Ebola outbreak illustrates how the lack of an effective health system can affect the ability of individuals, communities and societies to thrive and develop. Several factors associated with high poverty levels, fragile state systems and neglect of public health made those in the Ebola-affected countries particularly vulnerable to health shocks. They have high levels of exposure to many infectious diseases associated with inadequate disposal of human wastes, poor nutrition, crowded housing and uncontrolled breeding grounds for the insect vectors of malaria and other diseases. Table 1 shows the very low proportion of people with access to an improved sanitation facility and the relatively high levels of chronic malnutrition. Rapid urbanisation and movement between urban and rural areas means that new infections can spread quickly.

Table 1 Basic public health data

| | Sierra Leone | Liberia | Guinea | African region |
|---|--------------|---------|--------|----------------|
| Percentage of population using an improved sanitation facility (2012) | 13 | 17 | 19 | 33 |
| Percentage of population using improved drinking water sources (2012) | 60 | 75 | 75 | 66 |
| Percentage of children under 5 years with stunting (2006–12) | 44.9 | 41.8 | 35.8 | 39.9 |

Source: World Health Statistics (2014).

Table 2 summarises basic health system data for the three countries in comparison to the African region. At the time of the Ebola outbreak the three countries' health systems were fragile, due to limited public sector funding for many years and problems with public sector organisation, management and governance. During the immediate post-conflict period in Sierra Leone and Liberia the focus was on humanitarian assistance to a highly fragmented health sector, leaving people to seek solutions to everyday health problems in the private sector. Government health workers had evolved livelihood strategies to supplement very low pay. There were major problems with the quality of drugs and hospital care. Sierra Leone and Liberia had especially big shortages of health workers. In 2011 in Sierra Leone and Guinea the combination of government and external funding of the health sector was especially low; out-of-pocket payments by individuals accounted for a very high proportion of total health expenditure. A recent analysis argues that these very low levels of government spending on health were due, in part, to the terms of International Monetary Fund (IMF)

economic reform programmes (Kentikelenis *et al.* 2014). In Liberia, externally funded non-governmental organisations (NGOs) were important providers of health services.

Table 2 Basic health system data for 2011

| | Sierra Leone | Liberia | Guinea | African region |
|---|--------------|---------|--------|----------------|
| Physician density per 10,000 population | 0.2 | 0.1 | - | 2.6 |
| Nursing/midwife density per 10,000 population | 1.7 | 2.7 | - | 12 |
| Total health expenditure as % GDP | 16.3% | 15.6% | 6.0% | 6.2% |
| Health expenditure per capita at average exchange rate (US\$) | \$192 | \$92 | \$27 | \$99 |
| Gov't health expenditure as percentage of total | 16.2% | 29.7% | 24.3% | 48.3% |
| Private health expenditure as percentage of total | 83.8% | 70.3% | 75.7% | 51.7% |
| External funding as percentage of total health expenditure | 18.2% | 29.5% | 12.2% | 11.8% |
| Out-of-pocket expenditure as percentage of private health expenditure | 91.4% | 30.0% | 92.7% | 56.6% |

Source: World Health Statistics (2014).

During the late 2000s Sierra Leone and Liberia formulated national health system strengthening strategies. Both countries used donor funding to increase access to drugs and basic health services: Sierra Leone financed free health care for pregnant women and children and Liberia signed contracts with international NGOs to provide basic health services. These initiatives were politically popular and there is evidence they increased access to some health services. However, by 2014 only limited progress had been made in ensuring high levels of access to safe, effective basic health services and in addressing serious problems with governance and accountability. The inadequate response to the initial Ebola outbreak should not be a surprise. The shock of the epidemic and the threat to health workers' lives has further weakened the ability of local health services to help people cope with common illnesses. If remedial measures are not taken, this could greatly amplify the impact of the initial shock. The pre-existing challenges have been further complicated by involvement of international humanitarian agencies and foreign and local military staff in the response effort. This could create further fragmentation and parallel health systems.

Priority elements of a health system for resilience

There is a consensus about the health system elements key to building individuals' and communities' resilience in contexts of poverty and socioeconomic disruption. Most are included in the health sector development strategies of Sierra Leone and Liberia. Measures are needed to reduce exposure to infections by disposing of human wastes, preventing common infectious diseases and ensuring effective surveillance and response to potential epidemics. Action is needed to protect the population against dangerous practices and counterfeit drugs and to provide them with reliable, trustworthy information and advice. These are core government responsibilities in most countries, although the roles of national and local governments differ as do their partnerships with other actors. A clear allocation of responsibilities and central coordination are important. The growth of cities, with large peri-urban settlements and growing informal markets, poses new public health challenges. Many countries, including Guinea, Sierra Leone and Liberia, have neglected basic public health, health surveillance and health regulation functions.

People need access to effective treatment of common health problems. Many countries have trained community and/or basic health workers to provide advice and supply essential drugs. In some settings informal providers, including indigenous healers, provide a large proportion of health care, particularly to the poor. All these must work within a framework that provides adequate training, monitoring, supervision and technical support, and enables them to earn a living. Government, NGOs, faith-based organisations and other service delivery organisations can provide this support. Without it, these health workers are likely to become private drug-sellers, who deliver low-quality care and take little responsibility for public health.

The outbreak has illustrated the need for competent hospitals that people trust, complemented by international capacity to provide swift specialist support during an epidemic. Hospitals are complex; they need competent management and governance oversight to ensure safety and effectiveness of care. One plausible explanation for people's unwillingness to use local hospitals in the current outbreak is a fear of catching Ebola.

Health services are highly labour-intensive. Health workers' performance is strongly influenced by the degree to which their roles and responsibilities are clearly defined and recognised in terms of present and future livelihoods. There has been talk of how to harness 'community-based responses' to Ebola; examples of people being paid to work in burial teams; and speculation about the value of enlisting those who have recovered from Ebola, probably with a degree of

immunity. Any short-term measures will need to keep in mind the importance of building longer-term relationships between health workers and the individuals and communities they serve. In the case of the HIV epidemic in Africa, the strain on human resources led to experimentation in task-shifting and task-sharing; in training HIV-positive people as peer educators and activists; and in holding the state to account for lack of delivery of services.

How individuals protect the health of their families and communities plays an important role in building resilience. It relies on their having access to relevant information and on creating opportunities for community engagement and participation in health promotion activities.

Re-establishing a social contract: Government legitimacy and a trustworthy system

Since the mid-nineteenth century, an important element of a government's legitimacy has been its capacity to protect the public's health. An effective health system is built on trust: that health workers are competent and act in their patients' interest; health services function effectively; regulatory agencies protect the public against dangerous practices and sub-standard drugs; government is competent and prioritises the public interest. The fact that people have avoided health facilities and sometimes actively resisted public health teams, raises questions about their level of trust in them. Studies of people's attitudes confirm this.

A crisis such as the Ebola epidemic can increase the legitimacy of a government seen to be acting effectively. It can also undermine this legitimacy if the response is perceived to be incompetent or overly influenced by special interests. Strategies for building trust need to be based on understanding the historical legacy and how this affects attitudes towards government. Relationships of trust can be built by providing health services that local people believe to be safe and effective and by preventing serious abuses of power. The attitudes of health workers are important elements of a new social contract. These are influenced by the context within which they work, including fair levels of pay, availability of drugs and equipment, and ongoing training and supervision. A fine-grained understanding is required of the relationships between health system managers, health workers and the population. This is crucial to analysing how trust can be rebuilt. Health systems that incorporate mechanisms for community engagement and client feedback are more able to be responsive and people-centred.

Governments on their own are unlikely to be able to reconstruct the health system and build new and lasting relationships of trust. They will need to work with other organisations that already have social legitimacy, such as faith-based health facilities, NGOs and community structures. It is important that their relative roles and responsibilities are defined and arrangements established to make them answerable to a national governance body. Government will lead this body but could involve other organisations with social legitimacy.

The longer term

The long involvement of some of the authors of this Practice Paper In Brief in efforts to strengthen the delivery of health services in northern Nigeria offers useful lessons for post-epidemic reconstruction. First, health system strengthening is a lengthy process, requiring consistent political, financial and technical support. Second, it is important to address fragmentation in the health sector, which makes it difficult to define roles and responsibilities, hold service providers to account and manage services efficiently and effectively. This is a major undertaking which has to change deeply ingrained administrative practices and political preferences. Third is the need to manage human resources effectively to ensure there is an alignment between the responsibilities of health workers and ways to motivate them through payment, career progression and so forth. Fourth is the deeply political nature of health system reform and development, and the need to integrate governance reform with health systems strengthening. It is important to provide immediate benefits to the population, for example by making some services free of charge, but these measures need to be taken in the context of a realistic, long-term vision of health system change. Fifth is the need to build policymaker and community support for systems strengthening. This means involving local leaders in the design of interventions and keeping them informed about the health system's performance. International actors' actions that focus narrowly on short-term objectives or advocate for particular organisational arrangements can damage long-term efforts to build a coherent and effective health system.

Implications and future directions

The emergency response to the Ebola epidemic must factor in the need to build an effective health system, contributing to social resilience and supporting economic and social development. The management of the response will have a major impact on post-epidemic reconstruction.

- Even during the epidemic, government and development partners must take a long-term view, engaging with international NGOs and others to ensure their activities in dealing with the epidemic are aligned with the planned post-epidemic health system.

Strengthening Health Systems for Resilience

- Roles and responsibilities for ensuring basic public health must be defined at different levels of government and ministries, and in the private sector.
- Organisations must be identified which have the public's trust and the capacity to oversee provision of essential health services. These may include local government, NGOs, faith-based organisations, community groups and other civil society organisations.
- Contracts will be needed to define appropriate services and funding commitments. One important element of these will be health workers' roles and responsibilities, sources of livelihood and career prospects.
- Sustainable health financing mechanisms, including mechanisms to increase value for money and enhance accountability, are crucial; these will attract more resources for improving quality of services, in turn building trust in these services.
- Support will be needed to re-establish basic hospitals, rebuild trust in these and create close relationships between hospitals and primary health care services.
- The government must build its capacity to lead the response to both the crisis and post-crisis reconstruction, in partnership with other organisations with social legitimacy.
- Development partners must recognise the importance of an effective health system and avoid actions that make institution-building more difficult. This will involve coordinating all bilateral and multilateral agencies to ensure that health system support projects and programmes are coherent and that adequate provision is made in macroeconomic strategies for funding necessary health services.
- There are important lessons regarding effective international response at scale. Who will ensure effective surveillance? What will trigger a response? Who will provide rapid technical support? Who will provide a larger scale response, should another epidemic take hold? This is an essential element of national, regional and global resilience.

Further reading

Agyepong (2014); Amnesty International (2011); Bertone *et al.* (2014); Eldon and Waddington (2008); McKenzie *et al.* (2014); Sondorp and Coolen (2012).

References

- Agyepong, I. (2014) 'A Systems View and Lessons from the Ongoing Ebola Virus Disease Outbreak in West Africa', *Ghana Medical Journal* 48.3: 168–72
- Amnesty International (2011) *At a Crossroads: Sierra Leone's Free Health Care Policy*, London: Amnesty International
- Bertone, M.; Samai, M.; Edem-Hotah, J. and Witter, S. (2014) 'A Window of Opportunity for Reform in Post-Conflict Settings? The Case of Human Resources for Health Policies in Sierra Leone, 2002–2012', *Conflict and Health* 8.11
- Eldon, J. and Waddington, C. (2008) *Health Systems Reconstruction: Can it Contribute to State-Building?*, London: HLSP Institute
- Kentikelenis, A.; King, L.; McKee, M. and Stuckler, D. (2014) 'The International Monetary Fund and the Ebola Outbreak', *The Lancet*, December, [http://dx.doi.org/10.1016/S2214-109X\(14\)70377-8](http://dx.doi.org/10.1016/S2214-109X(14)70377-8)
- McKenzie, A.; Abdulwahab, A.; Sokpo, E. and Mecaskey, J. (2014) 'Building a Resilient Health System: Lessons from Northern Nigeria and South Sudan', *IDS Working Paper*, Brighton: IDS
- Sondorp, E. and Coolen, A. (2012) *The Evolution of Health Service Delivery in the Liberian Health Sector between 2003 & 2010: A Policy Analysis*, The Hague: LSHTM & KIT
- WHO (2014) *World Health Statistics 2014: Part III Global Health Indicators*, Geneva: World Health Organization

Credits

This Practice Paper In Brief was written by Gerald Bloom, Hayley MacGregor, Andrew McKenzie and Emmanuel Sokpo. It was produced as part of the IDS Strengthening Evidence-based Policy programme, funded by UK Aid from the UK Department for International Development. The opinions expressed are those of the authors and do not necessarily reflect the views of IDS or the UK government's official policies.

Readers are encouraged to quote and reproduce material from issues of Practice Papers in Briefs in their own publications. In return, IDS requests due acknowledgement and quotes to be referenced as above.

© Institute of Development Studies, 2015



Institute of Development Studies Brighton BN1 9RE UK

T +44 (0) 1273 606261 F +44 (0) 1273 621202 E ids@ids.ac.uk W www.ids.ac.uk AG Level 2 Output ID: 559