

# **PROMOTING HEALTH EQUITY IN CONFLICT-AFFECTED FRAGILE STATES**

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By

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***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](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/](http://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.equinet africa.org](http://www.equinet africa.org)), and the Health Policy Unit of the London School of Hygiene in the United Kingdom ([www.lshtm.ac.uk/hpu](http://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 of determinants of health at global, regional and country level.

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**ACRONYMS**

CAP	Consolidated Appeals Process
CGD	Centre for Global Development
CHAP	Common Humanitarian Action Plan
CHF	Community Health Financing
CHI	Community Health Insurance
CMR	Crude Mortality Rate
CPIA	Country Political and Institutional Assessment
CSDH	Commission on Social Determinants of Health
DAC	Development Assistance Committee
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DRC	Democratic Republic of the Congo
FFS	Fee-for-service
FFT	Fee-for-treatment
HAC	Health Action in Crisis
IDA	International Development Association
IDP	Internally Displaced People
INGO	International Non-Governmental Organization
IRC	International Rescue Committee
KN	Knowledge Network
LICUS	Lower Income Countries Under Stress
LSHTM	London School of Hygiene and Tropical Medicine
MDGs	Millennium Development Goals
NGO	Non-Governmental Organization
OECD-DAC	Organisation for Economic Co-operation and Development- Development Assistance Committee
PRS	Poverty Reduction Strategy
SDH	Social Determinants of Health
TRM	Transitional Results Matrix
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNTAC	United Nations Transitional Authority
WHO	World Health Organization

## 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

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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

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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,<sup>1</sup> 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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<sup>1</sup> 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

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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.