Health System Strengthening and Conflict transformation in Fragile states

Case Study:

Memisa's flexible approach to a changing context in Ituri (DRC, 2002 – 2012)

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2. **Context**

The DRC has important governance and security problems since its independence in 1960. In Ituri, a region bordering Uganda and Sudan, a civil war went on between 1999 and 2006, ravaging the country and destroying infrastructure. The conflict, originally mainly ethnical between the Lendu and the Hema tribes, affected all layers of the population and lead to important population displacements and violations of human rights.

Many different humanitarian actors intervened, mostly with very specific target populations and short term objectives.

Memisa intervened at district and community level, and later also at provincial level, offering aid to a population of about 540 000 people.

3. **Brief description of the intervention**

Memisa's intervention was twofold: *emergency aid* to the camps and remaining health facilities was organized when the fighting was most heavy (2003 – 2006), and at the same time *structural aid* to three health districts was put in place, aiming to strengthen the health system at peripheral level by improving access to and quality of health care, prioritizing mothers and children. This was done more specifically by supplying equipment, medicines and technical support to the health facilities and financial support to the staff, and by installing a system of "fee for episode" payment, subsidized by the organization. Community participation was encouraged. The amount of the fee, for example, was decided in collaboration with the population, and in certain areas community based health insurance mechanisms were initiated.

The BDOM[1] of Bunia was the operating partner of Memisa until the creation of a sentinel office in Bunia in 2008. All along this period, they received technical support from Memisa, strengthening their capacity and that of the district management teams to guide the process of reconstructing the health system.

The provincial referral laboratory of Bunia also received support to be able to stay functioning and reactive to the many epidemics occurring.

4. **Brief description and reflection on the challenges encountered**

- The absence of leadership from the state; the BDOM substituted the state at the intermediary level.
- The repeated destruction of infrastructure and the ongoing insecurity; the Belgian government, as main donor of the project, fortunately accepted to continue the support.
- Important ethnic divisions sometimes using medical interventions to settle their conflicts (massacres in hospitals); Memisa's aid made no distinction of race, religion or ethnical background.
- Dispersed populations living in misery due to impaired agricultural production; combinations of medical and agricultural aid were organized later on for the ex-militia.
- Instability of the health work force due to the important security issues and to brain drain to the international NGO's; Memisa consciously avoided employing own staff but reinforced the government staff in the existing facilities.

[1] BDOM: "Bureau Diocésain des Oeuvres Médicales" – *the Diocese office for medical interventions*

- Lack of coordination among the different and many international and national actors; inter-agency meetings have nevertheless succeeded in avoiding certain overlaps and waste of resources.

5. Reflection on the (possible) contribution to conflict transformation

By favoring structural support to the existing facilities, reopening them and guaranteeing permanence of the services, the intervention contributed to putting in place a dynamic of hope, trust and reconstruction. It motivated the people to return to their home villages and helped in restoring a feeling of dignity and respect of human rights.

The technical support to the district management teams and to the intermediary level, motivated and helped them to regain leadership and to work united despite the conflict. The support to the referral lab guaranteed a fast response to epidemics, helping to decrease fear among the population.

6. Evidence of impact of intervention on health, health system and/ or conflict transformation

In a context of prolonged violence and multiple, sometimes chaotic interventions, we can illustrate the impact of structural support by some speaking examples:

- 2004 - 2005: Reopening of the hospital of Nyankunde which was completely shut down due to the conflict; with new medical equipment and supplies, the nursing staff regained their posts and restarted the activities. When the hospital started functioning again, the people came back.
- 2004 – 2005: Refugees in Uganda on the other side of Albert lake crossing the lake to come back to the hospital on the Congolese side in case of illness, instead of mounting the hill to go to the Ugandan hospital: despite the conflict, the trust in the medical care remained. The medical staff of the health district of Tchomia was motivated by the support of Memisa to resume their post. About 70 woman, brought in by canoe from the other side of the lake, had an emergency C-section in this period.
- 2004 : collaboration with community demobilization and reinsertion program of ex-military in Nizi. Health facilities in this area were also rehabilitated and equipped by Memisa.
- 2007 : Re-initialization of the intermediary level in Bunia: the government appointed responsible doctor, who was working for the BDOM instead, was motivated to take up his function again, his office was put in place and equipped. This lead to having a real health government representative for the province again, a function that was kept in place ever since.
- Whole period: Capacity building of many district management teams empowered them to start reconstructing the health system
- As of 2003: Local initiatives of risk-sharing were encouraged; even though the degree of real social protection would stay low, it constituted a certain safety net and feeling of security.
- As of 2002: The subsidized Fee-for-episode payment system, decided in collaboration with the population, lowered the threshold to access the consultations, and numbers of curative consultations increased in the health facilities, despite the conflict
- 2008: People volunteered to help cleaning the hospitals and rehabilitating health centers, and started bringing back medical equipment and material that was “lost” in the forest.

We can classify the interventions in 4 types, taking place in different periods of time and influencing in different ways the health system and/ or the conflict.

- Structural interventions to keep the facilities functional: health centers, hospitals, provincial lab, provincial Inspection
- Emergency interventions: food/ non-food/ medicines/ medical materiel and equipment
- Re-integration of ex-militia
- Rehabilitation and reconstruction of health facilities

To better illustrate and analyze the approaches in different periods, we will use the conceptual framework of Wim Van Damme et al. (figure 1) describing different stages in a non-development, non-emergency situation.

Figure 1: adapted from Wim Van Damme et al. "Primary Health Care vs. emergency medical assistance: a conceptual framework" (Health Policy and Planning, 2002)

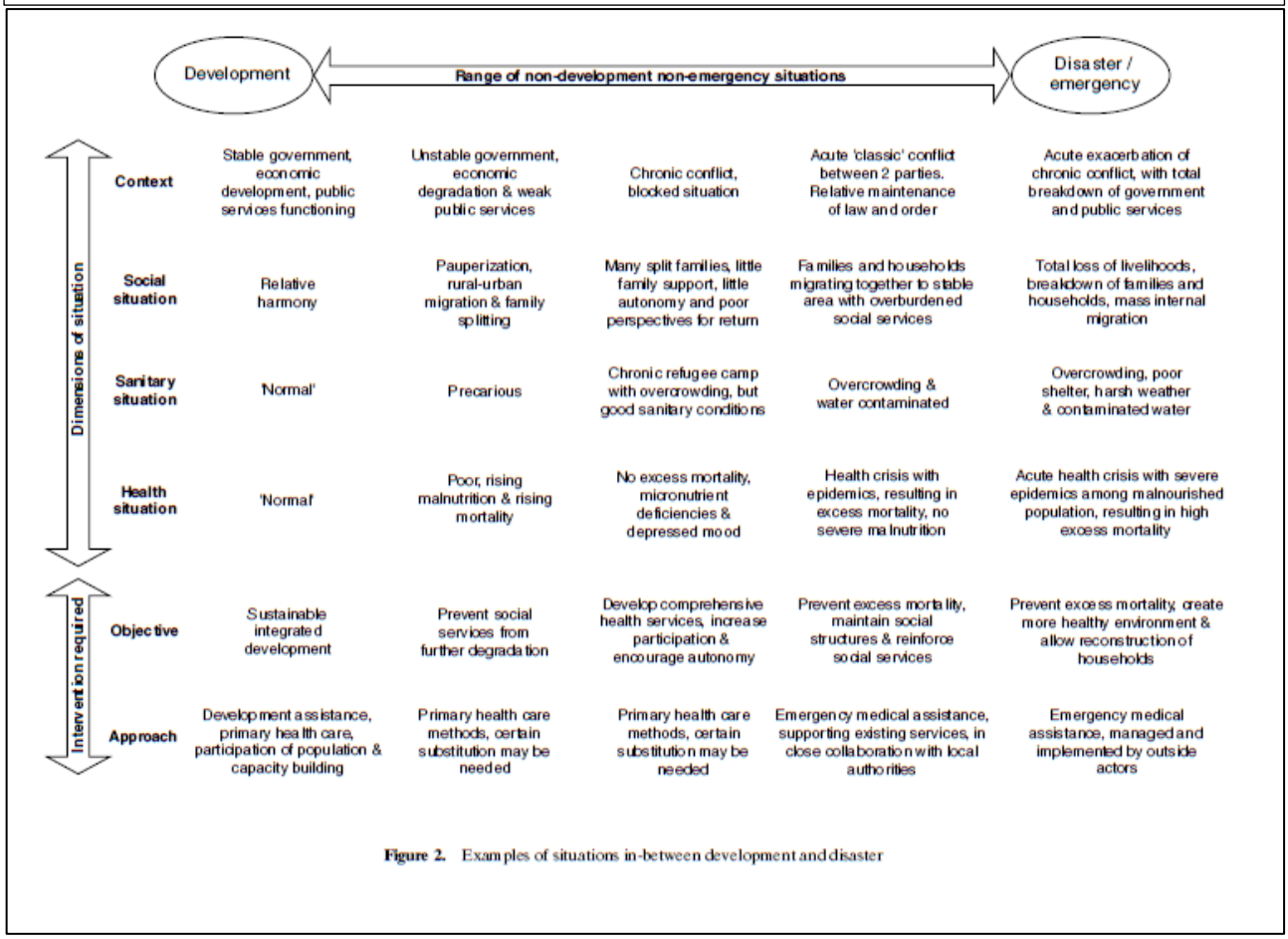

Figure 2. Examples of situations in-between development and disaster