Case Study on Health systems transformation and Conflict Transformation in Fragile States, for Medicus Mundi International, 11th of October 2012.

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Title:
Health interventions in fragile states: the role of politico-economic determinants.

Context:
This case study describes a reflection of 3 years of working experience on health in the conflict areas of Darfur (Sudan) and West-Papua (Indonesia) for NGO Médecins du Monde (MdM) .It describes the role of an international NGO in trying to improve the health situation and health services delivery, in situations where conflict has interrupted the regular health services. There is however strong differences between the regions and situation. The working experience in Darfur has been only 6 months, and includes (primary) health care service delivery in a refugee population, while the work in Papua took place in a remote highland area, in a district that has known a chronic low-conflict for more then a decade. This district, inhabited by indigenous population, has a high rate of migration from other parts of the country. With a prevalence of 3 -5% in the general population, it is also one of the districts with the highest HIV-prevalence's in the country. MdM for this reason supported the district in strengthening an HIV/AIDS clinic, sexual and reproductive health programs and primary health care. While reflecting on both the Darfur and West-Papuan health program, unfortunately little long-term health impact for the people or transformation of the conflict has been made. The case study tries to untangle what has been the positive impact and what has been the limitation of the interventions

Darfur, Sudan
MdM has been working from October 2004 – till February 2010 in Darfur. At first this was mainly via emergency aid in Kalma refugee camp, nearby Nyala South-Darfur, hosting more then 80.000 Internal Displaced Persons (IDPs). From 2006 onward, community health programs started in the Jebbel Marra Mountains, in an area where governmental structures had completely collapsed. MdM ran a Primary Health Care (PHC) and maternity clinic in Kalma, including a maternity and inpatient ward. These services were free of charge for the population. Secondary care could only be provided in the state hospital in Nyala city. The situation in Kalma camp and the role of NGOs have been described in more detail in two other publications[1][2]. Essence of these analyses was that quite large emergency medical aid was hastily set up with considerable amounts provided by institutional donors. The scale of these interventions could not be maintained due

[1] R. van de Pas. Darfur- dependent population at risk of another catastrophe. BMJ 2006;333:846-847
[2] R. van de Pas. People's Health in Darfur – Dependent communities. People's Health Movement. 2006

to the chronicity of the conflict and hence programs had to stop. I remember the conflict it *provoked* within the population when many NGOs had to leave the refugee camps and only some essential health services remained. On top of that conflict between several ethnic groups in the camp increased, so besides the *vertical* conflict, *horizontal* conflict over access to services and scare goods like food and firewood had actually increased. Undoubtedly, the NGOs and some local counterparts provided crucial and essential humanitarian aid, but they also contributed to this *horizontal* conflict. This could have been prevented by more coherent and coordinated efforts by the international community in consultation with local and traditional authorities. The reality is also that for many INGOs this was also a possibility to profile themselves, and receiving crucial funds for aid-relief. This *hindered* true cooperation and more importantly addressing the root causes of the conflict in the long term.

MdM realized this and decided from 2007 onward only to work at smaller scale community level and basic health care delivery in the Jebbel Marra. Due to armed conflict and political decisions to withhold NGOs access to the area and eventually the country, MdM was forced to withdraw on frequent basis and eventually had to completely stop the program. Looking back, there has been skillful diplomacy by the Sudanese government in politically "using" the NGOs as a tool towards the international community showing its goods intentions. NGOs were blocked access to Darfur after the International Criminal Court had issued an international arrest warrant for Sudan's president Omar Al-Bashir on crimes against humanity in Darfur. In short, humanitarian NGOs did provide essential emergency health services, but overtime *became unwillingly* part of the conflict.

West-Papua, Indonesia

MdM has been working for 13 years (1999-2012) in the remote highlands of West-Papua (the district of Puncak Jaya), the eastern-most province of Indonesia. It has supported HIV clinics, sexual and reproductive health programs, district health management as well as community health programs. This was done with local organization PRIMARI. Cordaid has funded this relative small program for many years until it decided to withdraw from health programs in Indonesia in 2011. The area is rich in natural resources (biggest goldmine in the world, Freeport McMorran is located in adjacent district), and Papua has still an enormous amount of untouched jungle and forests, while in the rest of Indonesia 70-80% of the total amount has been deforested or converted into palmoil plantations.

There has been a low-level conflict between an armed independence movement and the national army, which has led to a high level of militarization in the district. MdM has, with a range of local persons and networks, been working on socio-cultural aspects, and prevention, of sexually transmitted infections, supporting HIV and TB services, including introduction of ARV treatment, at PHC and hospital level. The experience over years has been that each time progress was

made, this was disrupted by either staff or management being replaced or relocated to other areas or that the conflict hindered health worker or community members to reach the health services. The turn-over of health staff has been considerable, while local community persons with a nursing or midwifery degree often choose to work in larger cities on the coast. There has been some consolidation on health service provision with church based organizations and key community persons. Although knowledge and capacities on (sexual and reproductive) health has increased, and the primary care services have improved to a certain extend, there have been *other* reasons that have much more impact on the health of the local population. The link between health and human rights in West-Papua has been described in two publications. [3] [4] In essence, denial of access to traditional lands and land conversions, strong demographic transitions due to migration, as well as the socio-economic marginalization and neglect of the political cultural rights of the indigenous people are much stronger determinants on the eventual population health status, eg via its negative effects on nutritional status and domestic violence, not to mention the abuse of alcohol. While focusing too much on *formal* health services and restricting itself to sexual and reproductive health issues, MdM has had too little impact on eventual health outcomes of the communities. It didn't allow itself to choose a clear *political* side by supporting the relevant local networks (because it would have automatically resulted in expulsion of the organization from the area) in relation to human rights abuses and very strong health inequities. While this has been done under the radar, the impact on health improvement has been too little.

These two experiences have led me to following **conclusions:**
While working on health systems and delivery in fragile areas, international organizations *are never* a neutral actor. Especially in our globalized economy NGOs are part of political systems that do have effects (whether negative or positive) on local developments that influence health. A good first step of NGOs would be to *recognize* their political position, as two authors (one of which is an aspirant MMI member) recently have promoted[5].

"We can and we must find ways to combine rescue, relief, charity and aid (some of which may be provided neutrally and with impartiality) with a political agenda that is NOT neutral but which sides firmly with the interests of the oppressed; the exploited; the poor. Perhaps this needs to be another element of the political strategy – how do we do both; without one compromising the other"[6].

[3] R. van de Pas. The right to health in Papua. Chapter 3.1 in: Human Rights in Papua 2010/2011. Faithbased network on West-Papua. Nov. 2011; p30-35
[4] SJ Rees, R. van de Pas, D. Silove and M. Kareth. Health and human security in West Papua. MJA 2008;189: 641–643
[5] Thomas Gebauer Aiding at change or abetting crimes? High time to re-politicise NGOs. http://www.medico.de/en/themes/campaigns/documents/high-time-to-re-politicise-ngos-/1225/
[6] David McCoy. Moving beyond medical rescue, to poverty reduction, sustainable development and justice? Presentation at the 13th Berlin Humanitarian congress, Oct. 28th 2011.

If I had to work on these programs again, I would have made a much more thorough political and socio-economic analysis of the situation before starting a health program, and secondly I would have aligned the organization more with community groups demanding social justice and claiming their socio-economic rights. I would make the link between health, services and these determinants much stronger. It would also make the health interventions more controversial and potentially NGOs to choose to abstain from certain health programs. But it would re-politicize NGOs to side with those people that face the negative side of globalization and conflict, and hence work on more structural changes for health.