



HARVARD MEDICAL SCHOOL
DEPARTMENT OF GLOBAL
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MEDICINE



NATO JOINT ANALYSIS
AND LESSONS LEARNED
CENTRE

TOWARDS A COMPREHENSIVE RESPONSE TO HEALTH SYSTEM STRENGTHENING

PROJECT CLOSURE

TOWARDS A COMPREHENSIVE RESPONSE TO HEALTH SYSTEM STRENGTHENING


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FOREWORD

Since 2011, NATO Allied Command Transformation's Joint Analysis and Lessons Learned Centre has partnered with Harvard Medical School to carry out a study to develop insights on strengthening state health systems in human security crises and the coordination of the civilian and military recovery efforts.

Linking security and global health has proven challenging but the importance of the security community's actions in crisis response is evident. The study's outcomes are an additional step towards greater coherence between the actions of civilian and military actors within the framework of a comprehensive political, civilian and military approach to crisis management.

We hope that this project's outcomes will somehow provide a different perspective to those involved in the management of crises.



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1. The Project Overview¹ document published in June 2012 set the stage for this study. Sections of that paper are reproduced as appropriate in this project closure report.

BACKGROUND

2. Human security crises, and international responses to them, are a regular feature of the global landscape. Human security crises not only affect the population directly but also threaten the systems upon which the population depends, which include the health system. The weak health systems in fragile states are especially vulnerable to crises that can further weaken or even destroy them, resulting in these states being unable to implement critical health programmes—such as ones addressing infant and maternal mortality—or to respond to threats such as epidemics. This inability to meet the essential health needs of the population is further linked with increased mortality rates and retarded economic growth.² The degradation of health systems may even undermine the population's confidence in the state itself, contributing to a cycle of increasing state fragility and deteriorating public services.³

3. Over the past decade, development and global health agencies have pursued new approaches to health development in fragile states based on the idea that health system strengthening is a key to sustaining health programmes long term.⁴ Notable advances have been achieved in health financing, organization of service delivery, and setting health system priorities using these approaches.⁵

THE REQUIREMENT FOR THIS STUDY PROJECT

4. In recent years, the number of global actors interested in health system strengthening has grown and so too has the number of approaches and frameworks. However, there has not been a corresponding growth in institutional arrangements to guide collective cohesive action. The crisis-affected fragile state is seldom able to lead and coordinate the global crisis response effort on its own. Ultimately, without adequate guidelines for coordination there is a risk that collectively global actors will not act optimally for the supported state's health system or may even find their actions are counter-productive.

5. But there are many challenges to harmonizing the actions of an increasing number of various actors interested in health system strengthening, both in preparing for future crises and when responding to an individual crisis. A particularly complex challenge in these respects is aligning the actions of the humanitarian and development and security communities which have been the focus of this study project. Both communities have an interest in health system strengthening. The humanitarian and development community is interested since health system strengthening is increasingly considered to be a prerequisite for reducing civilian mortality and morbidity in post-conflict settings, as well as achieving key development aims such as the Millennium Development Goals.⁶ The security community is interested since health system strengthening is increasingly understood to actively support, as well as be supported by, state stability.⁷

PROJECT AIM AND PURPOSE

6. A joint team from the Harvard Medical School Department of Global Health and Social Medicine, Brigham and Women's Division of Global Health and Social Equity, the Harvard Humanitarian Initiative, as well as military and civilian members of NATO's Joint Analysis and Lesson's Learned Centre (JALLC) have been involved in a study project since 2010 with the aim:

To infer elements of a strategic framework for health system strengthening in crisis-affected fragile states, focusing on the optimal use of contributions from global actors.

7. The purpose of this project as articulated by both NATO and Harvard was to examine how health system strengthening in crisis-affected fragile states is most affected, either directly or indirectly, by the activities of the security community, particularly through the employment of military capabilities. By doing so, it was anticipated that the Alliance could determine how to support the process of health system strengthening in the best manner within the scope of its crisis management core task.

Definitions

8. For the purposes of this study project, the team has adopted the following definitions for the humanitarian and development and security communities:

- a. Humanitarian and development community: Diverse group of civilian actors whose focus is to alleviate immediate human suffering caused by conflict or natural disaster, provide for the basic needs, and improve the conditions for long term economic and social growth.
- b. Security community: A diverse group of organizations that carries an internationally sanctioned mandate to use physical force if necessary in order to enforce the rule of law, restore public order, and maintain or enforce peace.

PROJECT APPROACH

Country Case Studies

9. The approach adopted to meet the aim and purpose of this project was based on case study research; this method was chosen given the need to understand a contemporary phenomenon in depth as well as within its historical and political context. The cases were selected based on three criteria. First, in each case a fragile state's health system was threatened by a human security crisis such as natural disaster, ethnic conflict, intrastate conflict, insurgency, or interstate conflict. Second, in each case there was a global crisis response directed towards health system strengthening, in some cases including military forces as part of their nation's contribution. Third, in each case a multinational military with a peace-keeping/building or stabilization mandate was present. The four cases studied are summarized in Table 1.

Table 1: Summary of the four country case studies

Case Study	Crisis affecting the Health System	Major Actors affecting the Health System	Multinational Security Mission(s)
Haiti (2010-2011)	Earthquake and cholera outbreak in unstable security environment	UN Agencies and Clusters, Embassies/GOs, NGOs, National health authorities, Foreign Military Forces	MINUSTAH
Libya ¹ (2011-2012)	Threat of mass atrocities addressed by violent military intervention	UN Agencies and Clusters, Embassies/GOs, ICRC, NGOs, Ministry of Health and Committee for the Care of the Injured, Crisis Mappers	OUP UNSMIL
Kosovo (1999-2012)	Threat of ethnic cleansing and regional war addressed by violent military intervention	UN Agencies and Clusters, Embassies, ICRC, Donors, OSCE, Ministry of Health	KFOR UNMIK EULEX
Afghanistan (2001-2012)	Threat of international terrorism and insurgency, addressed by violent military intervention	UN Agencies and Clusters, Embassies/GOs, ICRC, NGOs, Ministry of Health, Donors	ISAF OEF

¹ It is recognized that essentially Libya met only two of the three criteria established for case study selection. However, Libya remained a case study because the complex emergency and resulting challenges to the health system provide an opportunity to draw important enduring lessons.

10. A fifth potential country case study—the Democratic Republic of Congo—was deferred because of lack of resources, a risk identified in the Project Overview document.

Health System Framework

11. The World Health Organisation (WHO) Health System Framework (illustrated in Figure 1) was used as a base for analysis of the health system for each case study. This framework has as inputs six functional building blocks—service delivery, health workforce, information, medical products, vaccines & technologies, financing and leadership/governance—that together describe the elements of a system designed to provide intermediate outputs of healthcare access, coverage, quality and safety, ultimately to reach the four overall goals/outcomes—improved health (level and equity), responsiveness, social and financial risk protection, and improved efficiency.

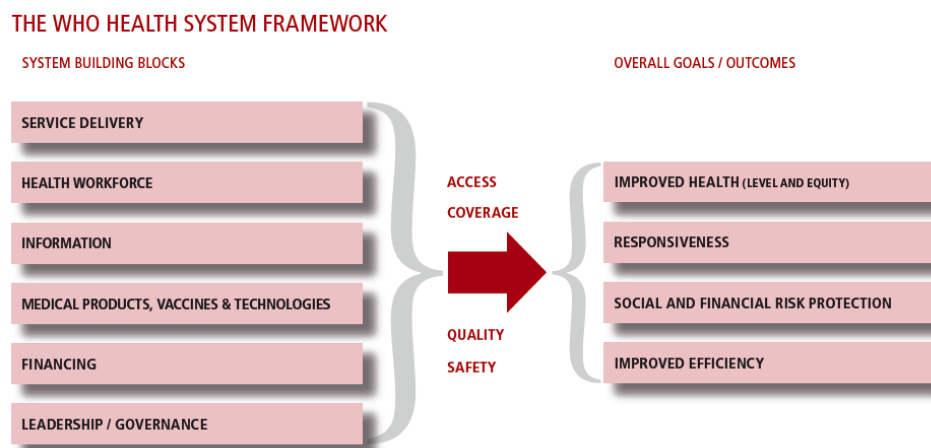


Figure 1: WHO Health System Framework⁸

Case Design

12. For each country case study, a combination of literature review, subject matter expert interviews, field work and interviews with case relevant stakeholders was used to:

- a. Describe the case context in terms of:
 - The health system before, during and after the crisis using the WHO Health System Framework.
 - The global crisis response directed towards health system strengthening in terms of the major organizations in the humanitarian & development and security communities involved and their mandates.
- b. Outline the major threats to the population's health relevant to the security community.
- c. Identify actions of the security community that directly or indirectly affected the health system.
- d. Develop rich narratives for a selection of security community actions that had widespread influence on one or more of the health system building blocks.

PROJECT TIMELINES AND DELIVERABLES

13. The planned timeline in the Project Overview proposed the following publication dates for the individual country case study reports:

- a. Haiti: second quarter 2012.
- b. Kosovo: third quarter 2012.

- c. Libya: fourth quarter 2012.
- d. Afghanistan: first quarter 2013.

14. Apart from the Haiti case study that was published in June 2012, these timescales, for many reasons, proved extremely optimistic and the other three country case studies—Kosovo, Libya and Afghanistan—were not published until the end of 2013.

PROJECT CLOSURE

15. An additional deliverable was planned, a final case synthesis of the four completed case studies which would infer elements of a strategic framework for strengthening health systems in crisis-affected fragile states. Although a draft paper was produced in second quarter 2013, it had not been published at the time of this project closure report (December 2013).

16. The significant delays incurred during this study project have had the cumulative effect that the project has now consumed all the assigned JALLC resources both financial and human. Additionally, both the JALLC project manager and the deliverable coordinator have completed their tour of duty at JALLC and have now departed from the organization. Consequently, the decision has been made to close the project with the publication of the four country case study reports and this project closure report. It is expected that a final synthesis will be published by Harvard Medical School sometime in the future.

KEY FINDINGS FROM THE COUNTRY CASE STUDIES

17. This chapter provides a very brief summary of the given health system and situational influences followed by key findings for each of the four country case studies.

HAITI

18. Haiti, an impoverished country with episodic political instability, faced two major disasters within one year: an earthquake followed by a cholera epidemic. The disasters differed in nature but both posed a significant challenge to Haiti's health system and a threat to the state's legitimacy. The United Nations (UN) peacekeeping mission MINUSTAH was already present in Haiti at the time of the earthquake; in support of the earthquake response, 26 countries deployed significant military assets including field hospitals and hospital ships.

Key Findings

19. The Haitian government lost significant assets—personnel, infrastructure, communications, records and administrative systems—at a time when their citizens were in the greatest peril and counting on them the most. Additionally, the aid community, including the UN peacekeeping mission MINUSTAH, UN agencies, and aid organizations were also severely affected by the earthquake and were unable to offer robust support of the Haitian state.

20. Nations responded principally by deploying military assets including logistics, security escorts, rubble clearance, engineering services, and tertiary care, all of which contributed significantly to the overall effort of the international community in responding to the earthquake; the US was the largest bilateral responder.

21. A coordination architecture for the whole response existed at the strategic level (High Level Coordination Committee), the operational level (Coordination Support Committee), and at the tactical level (UN sector-based cluster system). The key military tactical level coordination mechanism was the Joint Operations and Tasking Center, formed by UN Office for the Coordination of Humanitarian Affairs, MINUSTAH and other key partners, to orchestrate the use of military assets for relief purposes. The US Joint Task Force Haiti created the Humanitarian Assistance Coordination Centre to interface with the Coordination Support Committee and the Joint Operations and Tasking Centre.

22. Coordination among donor nations, the government of Haiti, UN agencies, militaries and relief agencies was a complex web. Personal relationships and friendships among leaders of response entities were instrumental in facilitating coordination mechanisms.

23. During both the earthquake and the cholera responses, there were difficulties and missed opportunities in processing and sharing important situation awareness information among all actors, despite considerable efforts to do so. However, new ways and means of collecting, processing and visualizing data—for example, social media, cell phone tracking data, Geographic Information Systems (GIS), etc.—show significant potential to improve shared situation awareness.

24. All of the above lead to the overarching finding from the Haiti case study: coordination mechanisms and institutional arrangements necessary to undertake a disaster response of this size and magnitude remain underdeveloped and inefficient.

KOSOVO

25. Since the 1980s, Kosovo has suffered the effects of ethnic violence, persecution and segregation: the health sector was also impacted by this situation. Years of devastation and

violence culminated in 1999 with the NATO 77-day air campaign against Milošević's regime and in what has been described as the "the largest refugee crisis in Europe since WWII". Years of neglect, underfunding and finally the war left the Kosovar health sector in poor condition, and poor sanitation created favourable circumstances for the outbreak and spread of disease. To address this situation, the international community invested millions of dollars, and much human effort, in rebuilding Kosovo and its health sector. Security community actors—UNMIK, EULEX and KFOR—were involved in this effort.

Key Findings

26. Immediately after the war, international actors and donors were engaged in rebuilding the health sector heavily affected by the war. The implementation of a new and modern health system, more decentralized and sustainable was considered the best model for Kosovo. This ambitious project was a mixed success. Healthcare delivery, such as decentralization to municipalities and, partially, health system reorientation to primary care, and workforce training were successfully implemented. However, the participation of local healthcare workers, both Kosovar Albanians and Kosovar Serbians, was poor in both the design and subsequent implementation of the new health system. Moreover, few investments have been dedicated to management and governance structures, such as transparent financing/procurements system and health information systems; consequently, there is a high risk of corruption and limited managerial capabilities in Kosovo's health system. Since 2008, EULEX has taken action as part of its Rule of Law Mission to counter and prevent corruption in Kosovo.

27. In addition to creating a safe and secure environment, a prerequisite for the reconstruction and development effort, KFOR was heavily engaged in the humanitarian response in the immediate aftermath of the Kosovo crisis. Some security community actions to detect and counter public health threats proved effective in the short term, but less so in the longer term. Such was the case of Mitroviça, where KFOR's initial actions to protect its soldiers and the local population from serious lead contamination had indirect consequences that still impact national health and the local economy today.

28. Coordination was notably lacking among host nation government actors and international actors from the humanitarian & development and security communities during the initial crisis response, and in health system strengthening in the longer term, which may have contributed to slow implementation of the new health system.

LIBYA

29. Libya's health system was threatened by an 8-month civil war during which the international military community intervened under a UN mandate to protect civilians. During and after the conflict, the international community contributed to strengthening the Libyan health system. However, the difference between this case study and the other three case studies done for this project—Haiti, Kosovo and Afghanistan—is that no troops, beside a handful of special advisors under national authority, were deployed on the ground during the international community's military intervention, and the present UN support mission does not include any international military force.

Key Findings

30. From a long-term perspective, the Libyan conflict in 2011 did not significantly impact the health system compared with the effects of years of poor management by the Gadhafi administration. Some significant assets such as health system personnel and certain infrastructure were lost but only for a limited period of time.

31. The security community had a major and positive impact on preserving the Libyan health system and infrastructures during the intervention in Libya, principally through careful

targeting to avoid collateral damage and facilitating humanitarian operations. The involvement of the security community in Libya after the conflict has been minimal.

32. The humanitarian community, coordinated by UN agencies, was able to provide robust support to meet the needs of displaced populations. As a consequence, direct military aid to the population was very limited, with an example being the treatment of war wounded in Libya's neighbouring countries.

33. The sharing of information between humanitarian and security communities, including the health situation, mainly focused on de-confliction of military and humanitarian operations. This information sharing was limited but reportedly good; the cooperation between the UN Office for the Coordination of Humanitarian Affairs (OCHA) and NATO's SHAPE being notably successful.

34. Two years after the end of the conflict, a comprehensive post-conflict assessment of the health system has not yet been finalized. Little tangible progress has been made to strengthen the Libyan health system despite an economic recovery. The Libyan government has ownership of the process to rebuild and strengthen the health system, but the country remains fragile and is facing growing instability, and has not yet been able to define a new political and social framework.

AFGHANISTAN

35. Afghanistan is a country that is experiencing the cumulative effects of over three decades of war and instability. Since 2001, the international community has contributed billions of dollars and much human effort towards stabilizing and rebuilding Afghanistan, including its health system. The NATO-led International Security Assistance Force (ISAF) has supported the government of Afghanistan in multiple ways to establish viable health systems in both the military and civilian sectors.

Key Findings

36. In Afghanistan, the security community has not been able to establish to date a consistently secure environment throughout the whole country, and therefore development has suffered in insecure areas. Because health is seen as a key component of development—and improved health is expected to contribute to stability—the security community supported and invested in health development programmes. However, Afghanistan provides scant evidence to support the notion that health system strengthening improves stability or supports counter-insurgency efforts.

37. Sustained insecurity and violence continue to have a major impact on the provision of healthcare. These ongoing concerns compel the humanitarian & development community and security community actors to share the same operating space, creating a wide range of issues in terms of coordination among: relief and development; civil and military; public and private; donors and service providers. Areas of responsibility between the various actors became blurred, creating the potential for the perceived impartiality of civilian actors to be eroded.

38. The Afghanistan case study demonstrates that humanitarian organizations are often uncomfortable with the involvement of the security community in the health sphere; this tension can result in limitations on the extent to which the security community can be involved in specific health and development efforts.

39. Each of the four country case studies offered conclusions which reflected the successes and challenges of the security community in investing in health system strengthening in crisis situations. This chapter highlights the fundamental key points.

40. The majority of the actors from the security, development and humanitarian communities agree that a safe and secure environment is a decisive condition for effective health system strengthening, a condition which necessarily requires the engagement of the security community.

41. Coordination and mutual understanding among the key actors from the humanitarian, development and security communities are crucial to ensure coherent responses to health needs by all involved. Interaction is essential among the key health sector actors from both civilian and military communities.

42. Lack of health system governance causes not only inefficient management in the health sector, but also may provide the opportunity for corruption, the combating of which demands a continuing commitment from security community actors.

43. No proof was found that the success of direct medical engagements led by security actors contributes to a wider strategy to win hearts and minds. Direct health interventions by military actors have even been recognized to be counter-productive at times because they undermined the confidence of the people in the capabilities of local and national government—i.e. Ministry of Health—and so hindered the development of capacity in the public health system. However, there have been other notable successes where medical programmes were carefully aligned with overarching campaign objectives which promoted the credibility and capacity of the host nation.

44. Regarding the specific contribution of the security community to healthcare, engaging in the promotion of health is very different from engaging in the promotion of a health system. Whereas health needs may be able to be met through the employment of specific military assets in the short term, strengthening an entire health system needs long-term solutions and strategies that are not always clear and are often beyond the mandate, and maybe the capability, of the security community.

45. The security community impacted health systems in a wide array of ways throughout the cases. The security community's impacts on health sector governance, health information systems and health delivery emerged as cross cutting themes throughout the cases.

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