STAKEHOLDER MEETING

Centre for Global Health Security

Brussels 18 March 2015

BRIDGING THE GAP
CAERUS - EVIDENCE BASED POLICY FOR POST CRISIS STABILITY

CHATHAM HOUSE
The Royal Institute of International Affairs

Funded under the European Union's Seventh Framework Programme for Research, technological development and demonstration under the grant agreement n. 607960

The RIIA Team

- Louis Lillywhite – Lead (RIIA)
- Simon Rushton – RIIA & Sheffield University
- Stuart Gordon – RIIA & LSE
- Claire Munoz Parry – Project Manager (RIIA)
- Bhimsen Devkota – RIIA & Tribhuvan University, Nepal
- Philip Angelides – Research Assistant (RIIA)

RIIA Contribution

- Contributing our own research in area of health and conflict.
- Addressing with ECDPM overall policy implications of research.

RIIA: Research Focus

Concentrating on decision makers in conflict.

Preceded by literature review on "NSAG's and health provision" (Completed: Stuart Gordon).

Followed by two country studies.

- Nepal (Simon Rushton) & Myanmar (Stuart Gordon)
- Background Literature Review for each country.
- Field research in both countries.

Two round table meetings.

- One on Non-State Armed groups (next week in Geneva).
- One on implications of country studies?

Session on Non-State Armed Groups

- Any experience of interaction with NSAGs?
- Your views on barriers to enhancing their contribution to health, where motivated.
- Your views on how to motivate NSAGs to comply with IHL in area of health.
- Your views on what may be possible and what may be 'off limits'

RIIA/Chatham House

Country Studies

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Overview

Background on purpose, methods and timeline of the two country studies.

Brief overview of the preliminary literature review on the Nepal case.

(Preliminary literature review of Myanmar case to follow).

AIMS

Better understand healthcare decision-making during conflict and transition.

Wide range of potential decision-makers:

- National authorities (government)
- Other parties to the conflict (e.g. Non-state armed groups)
- Local implementers (recognition that there is often a disconnect between 'policy' and practice 'on the ground')
- External actors (IOs, NGOs etc)

Overall Research Questions

During conflict:
- Who was providing healthcare?
- Why?
- With what effects (political/strategic AND health)?

During transition and subsequently:
- How was health addressed by the parties to the conflict during the peace process?
- Who provided/provides healthcare post-conflict?

Case study selection criteria

- Timing: conflict ended, but ended relatively recently.
- Security.
- Access to key informants.
- *Prima facie* evidence that a variety of actors provided healthcare during conflict.
- Complementing other CAERUS country studies.

Case studies

1. Nepal: Simon & Bhimsen.

2. Myanmar/Thai border (after South Sudan and Sierra Leone ruled out): Stuart.

Methods 1: Literature review

Examining:

- The dynamics of the conflict (actors, issues, key events)
- Timeline of the conflict and transition to peace
- Indicators of health status (before, during, post-conflict)
- Development indicators (before, during, post-conflict)
- Review of existing peer reviewed literature on the provision of health services during the conflict and in the transition to peace.

Methods 2: Document analysis

Examining:

- Government reports/policy statements
- Statements/publications by non-state parties to conflict
- NGO reports
- Media reports

Methods 3: In-country fieldwork

Key informant interviews.

- Preliminary list of interviewees to be drawn up via background literature reviews, document collection and analysis, and consultation with in-country partners.
- Snowball methodology to identify further interviewees during the fieldwork process.

Methods 3: In-country fieldwork

Predicted primary targets for Key Informant Interviews:

- Central government;
- Regional/local government
- Military
- Non-state armed groups
- UN agencies
- Local NGOs
- International NGOs

Methods 4: In-country partners

Nepal: Dr. Bhimsen Devkota, Tribhuvan University.

- Has written on health (and education) during and post-conflict in Nepal
- Research on Maoist health service provision
- Access to government, former insurgents and international development actors.

Myanmar: TBC

Methods : Timelines

	Lit Review	Doc Analysis	Fieldwork
Nepal:	Done	Apr-Sep 15	April & Sep 15
Myanmar:	In progress	Jun-15	Recce Done TBD

Preliminary thoughts on Nepal

(based on prelim lit review):

Reminder of the overall RQs**:**

During conflict:

- Who providing healthcare?
- Why?
- With what effects (political/strategic AND health)?

During transition and subsequently:

- How was health addressed by the parties to the conflict during the peace process?
- Who provided/provides healthcare post-conflict?

The existing literature provides only partial answers to these questions. Will pick out 7 things arising from the preliminary literature review:

Nepal

1. Health services very underdeveloped prior to war – despite Nepal being seen by some as a 'model' of Primary Health Care.

   - Huge inequalities.

2. Some evidence on the impact of the conflict on health (both physical and mental).

   - e.g. Research on war wounds, mental health consequences, IDPs, and the consequences of torture

Nepal

3. Big debates/uncertainties about healthcare provision during the conflict, especially around motivations:

   a) To what extent did the Maoists deliberately disrupt/ target health services?

   - This is debated.

   b) Did the government seek to use health strategically/ politically?

   - Little direct evidence on this, although the ways in which doctors were victimised for treating Maoists and Maoists sympathisers is documented.

   c) To what extent did the Maoists seek to provide 'people's health services' to the general population (as opposed to providing treatment to their own insurgents)?

   - We know that they did, but it is unclear how widespread this was – and there is lots of propaganda (on both sides) around this.

Nepal

4. We know little about the impact of the healthcare provision by either side in the conflict (either in terms of political or health gains).

5. External actors: Not a neat humanitarian aid to development transition: many development agencies were working in Nepal before the conflict and stayed throughout. They were supplemented by humanitarian actors – especially from 2003-6.

- We know little about the ways in which these different communities worked, or how closely they cooperated.

Nepal

6. How was health addressed by the parties during the peace process?

- we know little about this: the general literature on the peace process mentions health very little; it isn't systematically addressed in the peace accords. Was health service provision an issue?

7. The post-conflict picture:

- although Nepal is doing quite well against some key indicators, some of the literature suggests that inequalities have in fact widened. To what extent is there an issue here about the failure of the 'peace dividend' to materialise?

Thank you

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Non-State Armed Groups and Healthcare

Stuart Gordon Chatham House

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Scope

- Diversity
- Contribution
- Motivation
- How you can help us develop our research

- Policy Issues?

Diversity

- Warlords
- Militias
- Paramilitary forces
- Insurgencies
- Terrorist organizations
- Criminal organizations
- Youth gangs

- Challenge to the Westphalian order or permanent feature?

- Framing – as negatives (GWOT, Failed States, transnational criminality)
- Models
  - Greed
  - Proto state formation
  - Or Grievance
  - Intermediate – structure, multiple causal variables, forms of collaboration, rational delimitation of violence
  - Institutional theory and endogenous factors

Institutional Theory - Convergence

- Organizations adopt certain traits, structures and ways of operating in order to gain legitimacy within their environment.
- The consequence is that organizations with similar environmental domains tend to develop standard structures and processes.
- Not adhering to the institutional standards causes an organization to lose credibility with stakeholders.
- Homogenous evolution of military medical support networks – convergent evolution and institutional isomorphism
- Role of foreign 'norm' professionals
- Territorial control and civilian 'imaginaries' of government

Contribution to Healthcare

- Positive
  - Alternative Provision (Zapatistas, KNU, etc)
  - Only Provision (TPLF and KNU)
  - Governance and empowerment? (TPLF, Zapatistas)
- Neutral?
  - Domains of conflict
  - Naxalites and Maoists in Nepal
- Negative
  - Destruction (SPLM) Resource acquisition, Nihilism or the Club Model – Eli Berman *et al*
  - Obstruction
  - Treatment of wounded combatants/ ambulances – criminalization of the wounded – Syria and Maoists
  - Selectivity/co-option - Hezbollah
  - Reinforcing ethnic boundaries/ undermining or providing an alternative to the state – Hezbollah, Zapatistas, LTTE
  - Patronage/theft – Maoists, FARC and Sadrist militia
  - Tool of political competitions and socialisation
  - Broader impact of war on health systems

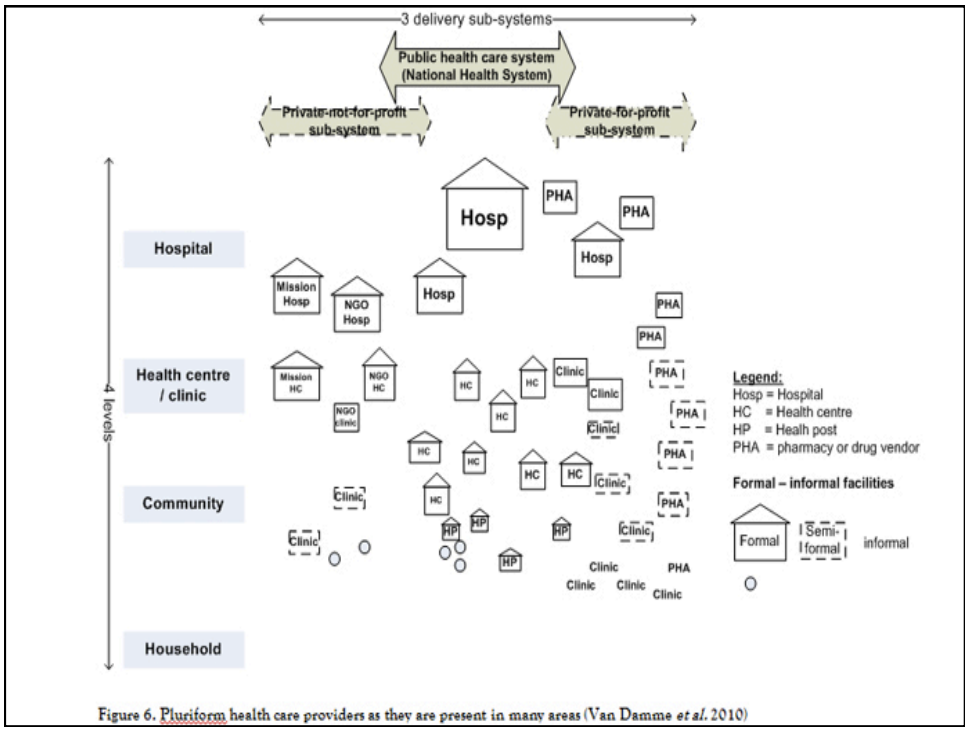

Figure 6. Pluriform health care providers as they are present in many areas (Van Damme *et al.* 2010)

What would we like from you?

- Any experience of interaction with NSAGs?
- Your views on barriers to enhancing their contribution to health, where motivated.
- Your views on how to motivate NSAGs to comply with IHL in area of health.
- Your views on what may be possible and what may be 'off limits'

Discussion