#1

The Martineau et al. article made a great point that any discussion on SDGs and universal health coverage cannot afford to ignore fragile and conflict affected settings. According to the researchers, communities, health workers, and systems are weakened by conflict, thus these three should be the starting points for policy development and system strengthening. In terms of communities, health financing policies need to match their needs (reducing cost of health care to address the process by which poverty is maintained at household levels). In terms of health workers, deployment systems need to ensure equitable distribution of health workers and incentives for them—these deployment systems also need to involve coordination by the multiple actors. Lastly, in terms of systems/institutions, policies need to involve coordination, distribution of power, and resource flows.

I found it interesting how the second article reframed the concept of resilience as meaning being resilient to day-to-day chronic challenges instead of just to acute shocks to the system.

Some examples of countries that have made the transition from conflict to post conflict and have rebuilt their health system in some way include Liberia (rebuilding health clinics post-war was the priority—to promote equity between urban and rural areas), Somalia (NGOs developed relationships with health ministries to promote service development), Cambodia, and Rwanda.

It seems that the characteristic of countries that have made successful transitions to well-functioning health systems post-conflict includes taking ownership for their own development activities (taking control of agenda).

The role of organizations like MSF, who provide services in the midst of conflict for the rebuilding of health systems post-conflict, seems to be one of filling the widening gaps in service provision and assisting in socio-economic recovery to return to a stability-like state and reduce the potential of returning to conflict.

#2

I have been looking forward  to this topic of health systems strengthening in post-conflict regions. The first article mentioned how despite conflict, some health systems (and they used Uganda as an example) have demonstrated resilience and ability to adapt to these environments. I personally have an example of this as it relates to events that happened in Northern Uganda.

Jane Ekayu is a Ugandan child trauma counselor and the founder and Executive Director of the non-profit organization, Children of Peace. And for a little background, until 2006, the Lord’s Resistance Army (LRA), headed by Kony, led a cruel guerrilla campaign in Northern Uganda and surrounding nations. At least 80% of the LRA forces were abducted children who were not only emotionally, physically, and sexually abused, but also coerced into committing unimaginable atrocities such as murdering families, even their own, and anyone who tried to escape. In the wake of this war-torn period, Children of Peace, Uganda (CPU) was established as a multifaceted, asset-based rehabilitation center for children and families who were victims of the violence. The organization is comprised of community health workers, social workers, financial advisors, and apiculturalists who all work together to address the mental, social, physical, economic and political well-being of this population.

I had the pleasure of working with Jane and CPU throughout my undergraduate years and I even had the opportunity to visit Uganda and observe their work. Jane created CPU from the ground up starting with no resources, no money, and fighting against a patriarchal culture.  CPU has definitely faced many limitations (of all different natures) but I think they are an example of efforts to rebuild health and the health system on a local scale.

And I think it is important to note how collaboration with outside groups can be vital.  CPU is supported entirely by outside organizations but at the same time its workforce is local. It is made up of individuals who are familiar with the area as well as the conflict. In the video about the health system in Rwanda, MSF was a supporting figure and were asking the hospitals and doctors (the ones who were most familiar with the situation on the ground) what they could offer, making sure they were attending to the community's needs.

#3

I'd like to take Vietnam as an example, in 1945, Socialist Republic of Vietnam declared independence, and the Vietnam government established the disability pension system with endowment insurance for soldiers. And this kind healthcare system expanded to all of the officers in public departments, including education department, hospitals and state-owned enterprises in 1961.However, the Vietnam War put the health system on hold, and impeded the development of universal health coverage.

After the national unity in 1975, the government began to launch the universal health coverage in whole country. The universal health coverage combined by endowment insurance, healthcare insurance, occupational injury insurance and death benefits. The employers paid for the insurance, while the government offered the subsidies. All of the residents could receive the free health care in Vietnam.

Thus, I think that a strong, powerful and unified regime could help the countrie made the transition from conflict to post conflict and  rebuilt a similar and more universal health system.

However, I also think about the Russia,  if the Cold War also could be a kind of "conflict " . Russia's health system changed a lot after the Cold War because of the collapse of  the Soviet Union.

Before the collaspse, most pharmacies and pharmaceutical factories were nationalised but it was not a uniform process.  Despite a doubling in the number of hospital beds and doctors per capita between 1950 and 1980, the lack of money that had been going into health was patently obvious. Some of the smaller hospitals had no radiology services, and a few had inadequate heating or water. After the collaspse, the  new Russia has changed to a mixed model of health care with private financing and provision running alongside state financing and provision. It looks like even the regime changed in a country, the universal healthcare still could be rebuilt.

#4

In the "Reframing Resilience" article, the authors began by acknowledging the critiques that a focus on resilience only of the health system ignores the political economy forces that shape and affect health systems/health system vulnerability, especially in LMICs, and that ignoring these forces allows for inaction on them. I am particularly interested in this critique, as someone who has studied international relations and international political economies. On one hand, crises certainly do expose and create vulnerabilities within the health system. On the other hand, these vulnerabilities might exist without the crisis, and are not necessarily constrained to the health system itself.

I found the reframing of resilience as laid out by the authors compelling, but I keep coming back to their first points of power imbalances and paying attention to political economy forces, not just crises, as engines of health system vulnerabilities. How might correcting these power imbalances help create less vulnerable health systems?  How might it decrease health system vulnerability in the first place? These might be more theoretical than applicable questions, but especially in the context of COVID-19, I think they are critical to think about.

To give these questions more real-world context, I think of the United States' ongoing sanctions against Iran in the midst of today's pandemic, as that shows the impact of both crisis and political economy. A quick Google search on "Iran sanctions pandemic" turns up various opinion articles with differing opinions, some declaring that health is not a good enough reason to end sanctions (which I personally find horrifying), many arguing that the death toll in Iran as a result of American sanctions is clearly not worth it. Here's an article giving more context: [https://www.theguardian.com/world/2020/mar/31/us-ignores-global-appeals-suspend-sanctions-coronavirus-pandemic-iran-venezuela. (Links to an external site.)](https://www.theguardian.com/world/2020/mar/31/us-ignores-global-appeals-suspend-sanctions-coronavirus-pandemic-iran-venezuela)

[(Links to an external site.)](https://www.theguardian.com/world/2020/mar/31/us-ignores-global-appeals-suspend-sanctions-coronavirus-pandemic-iran-venezuela)I do want to be clear that I have a particular bias when it comes to this that others may not agree with, as I tend to agree with scholars that argue that sanctions result in unacceptable human rights violations. I think that economic sanctions are a good vehicle to understand the impact of political economy forces on health, as the associations are so clear/attributable. Here are some articles about economic sanctions and right to health:

#5

I appreciated the distinction made by Barasa et al between everyday resilience and resilience to acute events. This category of resilience requires an understanding of health systems as complex and adaptive, as changing over time to fit a population's needs and enable the emergence of an order that is resilient to both chronic issues and shocks. This sentence in particular struck me: "within a complexity paradigm, nurturing resilience is about creating the conditions that enable system’s effectiveness—i.e.that enable desirable emergent future states by feeding the natural, bottom-up dynamics of emergence and innovation, rather than by imposing simple and mechanistic, cause and effect type solutions to current problems".

The dichotomy of hardware and software is interesting to explore in the context of that sentence, as it (to me) partly raises the question of, how emergent is this process really, or its idealized version in the authors' minds? Often, discourse over global health centers on policy decisions made by local and central governments.

 In this context, it makes sense to talk about such goals as more healthcare workers, more hospitals, etc. These are the structures that are absolutely required for a health system to function, and its hard to see them being erected from the bottom up. But  "productive cultures"? Healthy power dynamics among system actors? While undeniably worthy goals, these seem to truly require bottom up effort to see any real change -- they're not going to be legislated or regulated into existence, although perhaps ideas like codetermination might be a place to start. Are the authors calling for a move away from the policy focus?

One question I was a little unsure about from my reading is, why did the money for Rwanda's Human Resources for Health initiative come from PEPFAR, and not USAID or bilateral aid? Has PEPFAR taken on the role of medium through which generalized health funding is paid out?

#6

Both articles highlight some wonderful points on strategies and areas of focus that can serve as a framework to strengthen health systems within post-conflict eras. Martineau et al., highlights the importance and need of building a resilient, innovative research portfolio within FCAs as it plays a primary driver for implementing policy decisions at the institution, health worker, and community levels. I found this a very interesting proactive approach/strategy for rebuilding and strengthening the health systems as we are often taught/trained to react after the damage has been done, especially in public emergency or disaster situations. Adding to this, if we continue to advocate for robust real-time data collection, we can further provide this framework for other countries who may experience conflicts in the future and may need to rebuild their systems as well. By creating this framework, we may not need to have external organizations, like MSF or GlobalMedic, step in with disaster relief support, and essentially build countries to be resilient and sustainable with their internal resources.

Also interestingly while I was reading through the articles and commentary narratives on health system strengthening in a post-conflict environment, I found a great number of similarities between a post-conflict environment and the current COVID19 environment. I believe we learn a great deal and apply these similar strategies, lessons, and ideas in improving and strengthening even the developed nations health systems post COVID19.

Now I begin to wonder how do countries can rebuild health systems during global pandemic environment. For example, Yemen has been experiencing civil conflicts for quite some time now. With already weakened health systems, what would be the impact to their health systems with a COVID19 outbreak added onto existing conflict crisis?

#7

This is a very interesting topic because rebuilding any system is very difficult, talk less of one as complex as an effectively functional healthcare. Of course Rwanda was the first country that cam to mind when I saw this topic so it was not surprising that we discussed it in class. I won't belabor the points expressed by my classmates because I agree with most of them. What struck me from class was Dr. Streshley talking about the role of governance and speaking about how Kagame in Rwanda exploited DRC to help attain their current success. He went on to question why this wasn't the same outcome in DRC. This reminded of 'Dead Aid' by Dambisa Moyo who thinks the need of Africa is a benevolent dictator. Paul Kagame (President of Rwanda) is known to be both impressive and repressive as a leader, nonetheless, he set up vision 2020 which was for Rwanda to become an emerging nation. Major areas of focus was the economy and healthcare.

My food for thought for this week particularly in the African context is along the lines of Dambiso Moyo's thinking. Is a benevolent dictator really the way to rebuild in Africa? If so, where do we draw the line in order to transition from the rebuilding phase to the maintenance phase?