PRIORITY SETTING AND HEALTH SYSTEM RESPONSE TO CONFLICT SITUATION: A CASE STUDY OF YOBE STATE HEALTH SYSTEM

BY

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DEPARTMENT OF COMMUNITY MEDICINE
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DECLARATION

I declare that the work in this dissertation entitled “Priority setting in conflict situation: a case study of Yobe State health system” has been carried out by me in the department of Community Medicine. The information derived from the literature has been duly acknowledged in the text and a list of refrences provided. No part of this dissertation was previously presented for degree or diploma at this or any other institution.

Jibril Adamu Damazai ______________________ ______________________

Signature Date

CERTIFICATION

This dissertation entitled "Priority setting in conflict situation: a case study of Yobe State health system" by Jibril Adamu Damazai meets the regulations governing the award of Master of Public Health degree of Bayero University, Kano and is approved for its contribution to knowledge and literary presentation.

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Chairman, Supervisoary Committee Sign Date

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DEDICATION

This project work is dedicated to my parents, Mallam Adamu Damazai and Malama Nana Fatima Adamu Damazai.

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This work would not have been possible if not because of Allah's wish and guidance, for this and more my thanks is to Allah, the most high and the most merciful; may His blessing be upon his noble prophet Muhammad (S.A.W.).

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LIST OF ABREVIATIONS

CDC Centre for Disease Control

DFID Department for International Development

DALYs Disability Adjusted Life Years

EU European Union

ESP Essential Services Package

HCWs Health Care Workers

HRHHuman Resources for Health

HLF High-Level Forum

HPSP Health and Population Sector Programme

IDF Israeli Defence Force

IDP Internally Displaced Person

IDI Indepth Interview

LGA Local Government Authority

MLGCA Ministry of Local Government and Chieftaincy affairs

MMI Medicus Mundi International

MTEF Mid Term Expenditure Framework

MDTF Multi-donor Trust Fund

MSF Medicine San Frontier

MDGs Millenium Development Goals

NGO Non-GovernmentalOrganisation

NHI National Heelth Insurance

NSHDP National Strategic Health Development Plan

NHS National Health Survey

ODA Overseas Development Aid

PAHO Pan American Health Organization

QALYs Quality Adjusted Life Years

SMOH State Ministry of Health

SPHCB State primary health care board

UNHCR United Nation High Commission for Refugees

UAE United Arab Emerate

UNRWA United Nations Relief and Works Agency

UNDP United Nation Development Program

UNICEFUnited Nation Children Fund

UNAIDS United Nation Aids funded project

UNFPA United Nation Funds for population Activities

WAMU West African Monitory Union

WHO World Health organisation

ABSTRACT

INTRODUCTION: The major problem in health care prioritization is the need for new health care policies, which always exceed available budgetary funds, particularly in an economic environment characterized by shrunken budget. This situation requires policy makers to prioritize needs and actions into those that will make an impact and those that will not. Health policy challenges lies in reaching to fair decisions which adequately balance competing needs

METHOD: We used cross-sectional descriptive study design with mixed method of data collection among internally displaced persons (IDPs) and members of the communities. Both qualitative and quantitative method was employed in eliciting response from the study participants. And likert scale was used to score satisfaction with services provided by the HCWs in the camp.

RESULTS: The mean age of the IDPs was 28.9 + 8.9 years. Majority (90.9%) were between the age of 10 – 40 years upto 146 (65.5%) were females , 140 (62.8%) were muslims , 124 (55.6%) were currently married and 86 (38.5%) had atleast secondary school level of of education most of the IDPs were satisfied with access to health care on the camp; with waiting time to be attended at the facilities and with the attitude of the health workers working on the camps. Overall, all the clients interviewed(100%) were satisfied with services obtained from IDP Camps. The indepth interviews (IDI) with stakeholders revealed that hitherto the insurgency in Yobe state, health priorities were determined together with stakeholders in planning workshops conducted yearly in the state.

CONCLUSION: There were IDP camps managed by government with support from local and international NGOs, the services available are adequate. Similarly most of the IDPs were 100%

satisfied with services rendered by the HCWs such as access to health care ; waiting time to be attended at the facilities and with the attitude of the health workers working in the camps.

RECOMMENDATION

Although the insurgency has lasted for over six years the priority settings in the health care system within the state has significantly changed in line with the prevailing health problems cause by the insurgency. Because of the conflict situation, lack of enough human resources and deteriorating health condition on ground, the Governor declared state of emergency in the health sector, so as to respond appropriately to all the challenges health wise, And this has resulted to an increase in the budgetry allocation to the health sector.

.KEYWORDS: IDPs, Priority settings.

CHAPTER ONE

1.0 Introduction

A priority is a status established in order of importance or urgency'. Priority setting (also called prioritization) is the establishment of an order of importance or urgency among a set of items;' in other words, Means that, a choice between two or more alternatives and in practice the term refers to a situation whereby something more important is put before a less important one[2] in the context of the health system.[1]

Priority setting can also be defined as a resource distribution among competing needs and demands, and is one of the most important health planning tasks that face governments in seeking to enhance the distribution of health resources. This Priority setting occurs simultaneously at the macro (health system, meso (institutional) and micro which is (bedside) policy making levels.[1]

At the highest level, governments make decision regarding prioritizing health services in their annual budget and at the lowest level clinicians and other professionals set priorities regarding which patients to get services first. As long as there has been many health care problems to address, especially where there is deteriorating healthh funding in the system, there have been issues of health care priotization and rationing but the nature and the content of the processes will differ. This challenge is relevant in both developing and developed countries, while in developed countries challenges are mainly caused from aging population, expensive medical equipment's and increasing public demand, developing countries challenges are mainly the growing gap between health needs and available resources to satisfy them. [1]

1.2 Overview Of The Health System In Nigeria

The lives ofvast numbers of people lie in the hands of health systems. From the safe delivery of a healthy baby to the care with dignity of the frail elderly, health systems have a vital and continuing responsibility to people throughout the lifespan. They are crucial to the healthy development of individuals, families and societies everywhere.

Health systems are defined as comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personalhealth care,publichealthservicesor through inter-sectoral initiatives, whose primary purpose is to improve health.

But while improving health is clearly the main objective of a health system, it is not the

Only one. The objective of good health itself is really twofold: the best attainable average

Level – goodness – and the smallest feasible differences among individuals and groups –fairness. Goodnessmeans a health system responding well to what people expect of it;fairness means it responds equally well to everyone, without discrimination. World Health Organization expandsits traditional concern for people's physical and mental well-being to emphasize these other elements of goodness and fairness. Health system takes account of the roles people have as providers and consumers of health services, as financial contributors to health systems, as workers within them, and as citizens engaged in the responsible management, or stewardship of them.And it looks at how well or how badly systems address inequalities, how they respond

topeople’s expectations, and how much or how little they respect people’s dignity, rights andfreedoms.[2]

Furthermore, a health systemis the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently. A good health system improves people’s lives tangibly every day. A mother who gets a letter reminding her that her young son is due for immunization against a life-threatening illness is benefiting from a health system. The same holds true for a family finally able to access clean water at a well-tended pump in its village because of a government sponsored sanitation project; or a person with HIV/AIDS who gets antiretroviral medicine, nutritional counselling and regular check-ups at an affordable clinic.[3]

In pre-explorers and pre-western trader's Nigeria, traditional medicine was the system of health care delivery. Traditional healing and medical practices included herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons. In spite of more than 150 years of introduction of Western style medicine to Nigeria, traditional healing and medical practices remain a viable part of the complex health care system in Nigeria today. Although this traditional system of health evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. The origin of diseases in Africa was simplistic. It is either an enemy had cast a spell on you or you are being punished by divine powers for your sins. Although the Arabs have had the distinction of early-organized medicalservices, there is no recorded evidence of the introduction of such services to Sub-Saharan Nigeria during trade interactions of the fifteenth century[4].

From the available accounts, the earliest form of Western-style health care in Nigeria was provided by doctors brought by explorers and traders to cater for their own well being. The services were not available to the indigenes. It was the church missionaries that first established health care services for the people.[4] In this regard, tribute must be paid to the Roman Catholic mission, the Church Missionary Society (Anglican) and the American Baptist Mission. It is stated that the first health care facility in the country was a dispensary opened in 1880 by the Church Missionary Society in Obosi, followed by others in Onitsha and Ibadan in 1886. However, the first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885.[4]

At the turn of the century, medical services, as is the case with some other services, in Gambia, Sierra Leone, Ghana (then Gold Coast) and Nigeria were merged and controlled by the Colonial Office in London. This was the first centralization of control of health services in West Africa.[5] The Colonial Office determined the services that were available and provided the manpower. As health care management became more complex, the central administration of health care services became regionalized, while maintaining some common West African facilities such as the West African Council for Medical Research, which came into being in February 1954. In Nigeria specifically, medical services developed and expanded with industrialization. Most medical doctors were civil servants, except those working for missionary hospitals, who combined evangelical work with healing. Among the civil service doctors, one was appointed the Chief Medical Officer, who became the principal executor of health care policies in Nigeria. Along with his several other junior colleagues (Senior Medical Officers and Medical Officers), they formed the nucleus of the Ministry of Health in Lagos.

The health care services in Nigeria have been characterized by short-term planning, as is the case with the planning of most aspects of the Nigerian life. The major national development plans are as follows:

1. The First Colonial Development plan from 1945- 1955 (Decade of Development)
2. The Second Colonial Development plan from 1956- 1962
3. The First National Development Plan from 1962- 1968
4. The Second National Development Plan from 1970- 1975
5. The Third National Development Plan from 1975- 1980
6. The Fourth National Development Plan from 1981- 1985
7. Nigeria's Five year Strategic Plan from 2004 - 2008 All of these plans formulated goals for nationwide health care services.

The overall national policy for Nationwide Health Care Services was clearly stated in a 1954 Eastern Nigeria government report on "Policy for Medical and Health Services." This report stated that the aim was to provide national health services for ALL. The report emphasized that since urban services were well developed (by our standards then), the government intended to expand rural services. These rural services would be in the form of rural hospitals of 20- 24 beds, supervised by a medical officer, who would also supervise dispensaries, maternal and child welfare clinics and preventive work (such as sanitation workers). The policy made local governments contribute to the cost of developing and maintaining such rural services, with rants-in-aid from the regional government.

By the time the Third National Development Plan was produced in 1975, more than 20 years after the report mentioned above, not much had been done to achieve the goals of the Nationwide Health Care Services policy. This plan, which was described by General Yakubu Gowon, the then Head of the Military Government, as "A Monument to Progress", stated, "Development trends in the health sector have not been marked by any spectacular achievement during the past decade".

The Fourth National Development plan (1981- 1985) addressed the issue of preventive health services for the first time. The policy statement contained in this plan called for the implementation of the Basic Health Services Scheme (BHSS), which provides for the establishment of three levels of health care facilities; namely 1) Comprehensive Health Centers (CHC) to serve communities of more than 20, 000 people; 2) Primary Health Centers (PHC) to serve communities of 5000 to 20, 000 persons; and 3) Health Clinics (HC) to serve 2000 to 5000 persons. Thus, a CHC would have at least 1 PHC in it catchment area (ideally 4) and a PHC would have at least 1 HC in its catchment area (ideally 2). These institutions were to be built and operated by state and local governments with financial aid from the federal government. By this policy, the provision of health services would be the joint responsibility of the federal, state and local governments. In its outlook, this policy is not different from the one published in 1954 by the Eastern Nigerian Government previously mentioned.

Nigeria is currently made up of 36 states and over 500 local government areas. Each local government area (LGA) is made up of between 150, 000 to 250, 000 people. By the scheme proposed in the Fourth National Development plan, each LGA would have a minimum of 7

PHCs and 30 HCs with at least one CHC at the apex of the health care services. The larger LGAs would each have, at least 12 PHCs and 50 HCs feeding into one or more CHCs.[6]. On the last day of 1983, a new Military Government came into being in Nigeria and one of the reasons it gave for the Military intervention was the state of health services, declaring "our teaching hospitals have been reduced to mere consulting clinics." One of the government's first efforts was to revise the Fourth National Development Plan. The health strategy under this revised plan gradually shifted emphasis to primary health care. Although this has always been the ultimate goal of the plan, the political will did not seem to exist for its implementation. The adoption of the WHO target of Health for All by the Year 2000 by the federal government was marked by shifts in emphasis and structural changes in health care administration.

At the federal level, the Directorate of National Health planning had the function of coordination and implementation of the national health policy. It also had the function of developing plans for national health. At the state level, were state health advisory councils whose function it was to give general advice to the Commissioner of Health in the performance of his functions. At the local government level, the State Ministry of Local Government in consultation with the State Ministry of Health established Local Government Health Committees covering their area of authority for the purposes of formulating policies for providing health services to the communities. At the community level, several small communities had evolved small community

Primaryhealth care services with active community participation.

In more recent Nigeria, this lofty goal has not been achieved. The capacities of the facilities that emerged from previous efforts have been stretched and infrastructure broken beyond repair. Primary health care services now exist only in name. The common man has reverted to the herbalist and traditional healers for care because of access and affordability issues. The elites have perfected medical tourism to India, Singapore, South Africa and even Ghana. This is in the face of a rapidly changing disease patterns in which infectious diseases have been replaced by behavioral, environmental and poverty-related diseases.[6]

PROBLEM STATEMENT

The health care systems faces varying degrees of challenges/problems ranging from problems of justice and efficiency relating to certain priorities for allocating limited pools of resources to a population to provision of everyone with every effective intervention they might need or want, and due to scarcity of health resources it rises questions of justice and efficiency, how should limited health resources be allocated? What health services should be publicly funded? How should indications for particular interventions be defined?

The process of priority setting has traditionally been shaped by organizational cultures where norms and incentives have implicitly supported historically based resource allocation processes, in which in most health care organizations, the process related to the decision making is based on the previous years expenditure been rolled over to the current year, with some political and demographic adjustments, which can lead to "Allocation by stealth" and enable politics to directly enter to fray. However one of the major challenges been faced by the decision makers in

various organization across the countries is the dissatisfaction of the decision maker with these processes leading to desiring more explicit, evidence based approaches to priority setting. [7,8,9]

In addition, another major problem in health care prioritization is the need for new health care policies, which always exceed available budgetary funds, particularly in an economic environment characterized by shrunken budget. This situtation requires policy makers to prioritize needs and actions into those that will make an impact and those that will not. Health policy challenges lies in reaching to fair decisions which adequately balance competing needs. Itis key to this priority settings process to be aware of the opportunity cost of the different funding options as well as to capitalized in social legitimacy by involving large stakeholders groups.[10]

Since the late 1980 many governments have decided to institute transparent and explicit discussion about setting priorities for health care programmes, these efforts took different forms, which included health care experts, but they varies in the inclusion of government officials and public representative and also in the details of the frame works they outline. In most of the countries howevever the priority setting efforts failed due to political reasons to address the issues.[11,12]

In the UK and Scandinavian countries there where reports of patients denied potential life saving treatments, which include bone marrow transplantation for certain cancers, and of access to

health care in different parts of the country, labelled rationing by post code.[19] Similarly in Norway, the ever expanding waiting lists for treatment created political pressure for a system that would prioritize patients on waiting lists. [17,18] In some countries such as the Netherlands and Israel, New legislation regarding health insurance created a need to decide what services should be provided in package offered to all citizens and hence reducing the burden of prioritization.[12]

JUSTIFICATION

The success of every health intervention is base on initial identification of priority area especially in resources poor settings. The lack of adeqaute human, financial and material resources at all levels has made it almost impossible to achieve all desired health interventions. Therefore this necssittate the need for perioritation of every health health care intervention.

In 2002 most of the health programmes in Sweden failed as a result of lack of prioritization of the health programme due to political selfishness, in which most work on the substantive issues was left to local health authorities. [12] similarly, New Zealand in 2000 suffered set back in their health system due to lack of prioritization which later led to committee to discuss principles in much the same way as others to get to the root of the problem by prioritizing the health programme.[12]

Over the years, health planning in Yobe State as in the other state of the region had merely been

attempt to implement non-performing activities and intervention rolled over from the National strategic health development plan, scaled down to the states from the central federal government of Nigeria. Planning process has not been optionally effective perhaps because it has not been entirely based on priorities from health needs of the communities, but more of political agenda and personal needs of policy makers.

Since the emergence of the insurgences from the Boko Haram attacks and the enactment of emergency rule in Yobe State and other parts of the North-eastern Nigeria by Federal government of Nigeria, funding for health in Yobe has deteriorated further, many of the facilities available for the health care have also been distroyed from attacks and significant proportion of the human resources for health have fled the area, while majority of populace are internally displaced due to the insurgences. There is thus need to study how the decesion makers in the state set priorities for health delivery and maintaining the integrity of health system in the state.

The research questions are:

1. Does the leadership and governance for health changed to respond to health system demand?

2. How has the funding for health changed in response to the health system demand?

3. Does the service delivery structure change in response to the needs of the population?

4. What are the roles of public, private and NGO sectors in supporting service delivery?

1.2 OBJECTIVES

1.2.1 General Objectives

To determine how the Yobe State health system is responding to the deterioration from the recurrent Boko Haram Insurgences.

1.2.2 Specific Objectives

1. To determine the leadership and governance response of the health system to the conflict situation in the state.

2. To determine how funding for the health system hasaffected the response to the health systemdemand.

3. To determine how the service delivery structure has affected the response to the needs of the population.

4. To determine the roles of public, private and NGO sectors in supporting service delivery under the conflict situation.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The literature review was search using Google data base, PubMed, Hinari, WHO publications, local and internationnal jounals, Medline and Ajol info, using inverted funnel approach. The key terms used were "Priority setting, Prioritazation of health programmes, Selecting Priorities, Priority health setting".

Evidence based approaches in public health practice provide a systematic, objective framework that can inform policy and decision-making by establishing priorities that make maximal use of limited resources. Within the realm of humanitarian assistance, the evidence on how to respond to disasters has evolved: Public health specialists and Non-governmental Organizations (NGOs) have developed protocols for preparing for and managing responses to earthquakes, cyclones, natural disasters, and, sadly, endemic wars /conflict and evidence is emerging on how best to transition from humanitarian response to development .[14,] Little is known, however, about the added challenges of health sector development and health sector human resources management in frozen conflicts , where peace has been negotiated but international recognition of boundaries and authorities are lacking. Such is the situation found in Nagorno Karabagh, an ethnic Armenian territory locked within post-Soviet Azerbaijan.[14,15]

Setting priority for health programming and budget allocation is an important issue especially in fragile/emergency states, but there is little consensus on related processes, which is particularly

relevant in low resource settings and at province and district level where contextual influences may be greater, scarce information and lower capacity. The main objective was to assess priority setting process in an armed or crisis situations according to whether they have influenced resource allocation and impacted outcome indicators prioritised. [16,17] priority can be defined as a ‘’status established in order of importance or urgency, priority setting also called prioritization is the establishment of an order of importance or urgency among a set of items,[15]but in this research we are dealing with priority setting in fragile states or in conflict situation. A fragile state is considered "unable to perform basic functions such as maintaining security, enabling economic development, and ensuring the essential needs of the population are met.[18]They are characterized by weak policies, institutions, and governance. These states are not just poor or corrupt; they are understood as incapable of accomplishing basic functions including providing effective core services such as education, transportation, state financing and administration, justice, and health.[19]

The European priority setting for global health responded more urgently to issues of health security and the threat that global pandemics and outbreak could affect the health of European union (EU) citizens than to the poverty, equity and development challenges.In 2005, the European centre for disease prevention and control came into action by providing a point of coordination and technical support for the many European public health agencies and laboratories that provide international health surveillance and support for response to health emergencies.[14,15]

In conflict or post-conflict situations,health system re-construction becomes a critical component of ensuring stability. A study was conducted to determine the priorities for health system during crisis among Iraqi physicians residing in the northern region of the country. A convenience sample of practicing male and female physicians residing in the Kurdish region completed a 13-item survey about health system reconstruction. A total of 1001 practitioners completed the survey with gender breakdown of 29% female and 71% male, all working in different specialty areas. Significant differences between the providers based on gender,specialty and geographic location were found to affect the responses of the participants. This study demonstrates that input from healthcare professionals is important for health system reconstruction during crisis, but that gender, geography and medical specialty make the process complex.[20]

The health ofrefugees and other forcibly displaced people is a key component of protection and a priority for UNHCR. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to the highest standards of physical and mental health.[21]

UNHCR works closely with partner organizations who implement health programmes in a range of challenging settings. We play a planning, coordination, monitoring and evaluation role. Health and nutrition programmes are delivered within a public health and community development framework, with an emphasis on primary health care and support for secondary hospital care. The objective of these programmes is to minimize mortality and morbidity rates. Among forcibly displaced populations in developing countries, the top five killers of children under the age of five are malaria, malnutrition, measles, diarrhoea and respiratory tract infections.[22] The priorities

for UNHCR and its partners at the start of an emergency are measles immunization, nutritional support, control of communicable diseases and epidemics, implementation of the reproduction health measures and public health surveillance. As the situation stabilizes these services are enlarged. In more developed and urban settings, public health priorities among adults shift toward cardiovascular and chronic diseases and cancers.[22]

New Zealand established its national advisory committee on core health around 2005 together with disability support services to evaluate which services should be included in the publicly funded health package in the presence of disaster (eg floading) , which at the end the commission concluded that existing practices represented an ad-hoc list of priorities and the core services committee started with this list and worked to identify, areas where efficiency could be improved and preferences of communities regarding health care.[21]

In Israel the government passed a National Health Insurance (NHI) Law, which Guarantee Health Insurance coverage to all citizens including victims of war crisis, and would be provided by competing private sick funds with the government acting as the single player, when the above law adopted , the government decided that the basket comprising the extensive list of services offered by the largest existing sick fund at that time would also be the basic basket covered under the law.[22,23]

2.2 Effect Of Conflict On The Health System

The role of health in development and aid policy in conflict-affected and fragile states remains

Of agreat concern all over the world. Evidence is increasing that conflict and fragility have a devastating impact on health. At the same time, knowledge on how to construct effective and sustainable health systems in these states through local leadership and donor commitment is expanding. Yet, except in countries of strategic or political interest to donors, such as Afghanistan, Iraq, or the Balkans. Moreover, the policy animating these investments ismurky, a mixture of health goals and political objectives relating to stabilization and counterterrorism.
Whether health investments can and should advance those political goals remains highly contested. At the same time, the conventional distinction between emergency health interventions and humanitarian relief on the one hand and health development on the other, although reflected in funding streams, often makes little sense on the ground. Conflict and fragility tend to be protracted, but health systems development can often proceed even before peace and stability are established. Further, fragility or conflict, and its attendant impacts on health, may well affect one or more regions of the country rather than its entirety.
No consensus has yet been reached on a definition of a fragile or post-conflict state. Generally,though, a fragile state is considered "unable to perform basic functions such as maintaining security, enabling economic development, and ensuring the essential needs of the population are met." They are "characterized by weak policies, institutions, and governance." These states are not just poor or corrupt; they are understood as incapable of accomplishing basic functions including providing effective core services such as education, transportation, state financing and administration, justice, and health. Some states experience fragility as a result of a political crisis while others are fragile for decades and intermittently erupt into violent conflict. Conflict-affected states are easier to identify, though organizations that track conflicts use varied definitions of conflict based on indicators such as number of casualties or extent of fighting. The

distinction between conflict and post-conflict status is imprecise because some conflicts become chronic, and displaced persons and refugees remain in camps or otherwise without permanent settlement for decades. In other states, a formal end to a conflict is replaced by high levels of continuing violence and instability, sometimes including renewal of war. An estimated one-sixth of the world's population live in fragile or conflict-affected states.[24,25] Approximately 310,000 deaths were caused by conflict in the year 2000 with more than half occurring in sub-Saharan Africa . Multiple researchers have found that the largest number of conflict deaths occurred among children and adolescents, but that nearly 25 percent of deaths were among women. Excess deaths of males between the ages of 15 and 44 also impact the working age population's productivity. The World Health Organization (WHO) estimated that 0.70 percent of the global burden of disease in the year 2000 was due to conflict. Since this places conflict-related deaths well below other burdens, it is not considered a high priority by the international community. However, this is a mistake because of the many health outcomes of violent civil conflict that persist for years, or are not apparent until years after the conflict.[26,27,28]

Populations affected by armed conflict experience severe public health consequences mediated by population displacement, food scarcity, and the collapse of basic health services, which together often give rise to complex humanitarian emergencies. Conflict has both direct and indirect effects on people's health and on the overall health system. Armed conflicts can also cause the displacement of people and an increase in infectious diseases.[28]

Nepal recently emerged from a decade-long violent conflict (1996 to 2006). This violent conflict had an effect on both the population's health and the health care system.It led to over 13,000

fatalities , the disappearance of at least 1,200 people , the disablement of thousands of people, and the internal displacement of many more . Over 1,000 health posts in rural areas were destroyed , more than a dozen health workers had been killed and many others were harassed, kidnapped, threatened and prosecuted by the warring factions . The conflict aggravated the already poor health services as one third of Nepal's health centers is in rural areas and often operates without health staff. Torture and sexual-abuse related to insurgency were also prominent, and the conflict also hindered health programs implemented by non-governmental organisation.[29,30]

Since achieving independence from Britain in 1948, Sri Lanka experienced two major armed conflicts that effectively impacted on the whole country. The Janatha Vimukthi Peramuna (JVP), a leftist organization involving mainly Sinhalese youth, led two insurgencies in the southern part of the country, first in 1971 and later between 1987-1990. Around 60,000 people were killedduring these episodes, and included JVP cadres, membersof the armed forces and civilians. While major population movements were not triggered by these events, a considerable number of individuals and families were displaced from their homes, mainly due to prosecution by various factions involved.

Conflict-driven forced displacement precipitates physical ill health among affected populations, during pre-flight, flight and post-flight periods. In addition, conflict situations increase public health problems, compounded by existing health disparities. In the Sri Lankan conflict setting, published studies provide evidence of health system disruption, public health issues affecting displaced populations, increased mortality, morbidity and disease burden (quantified by quality

adjusted life years QALYs or disability adjusted life years - DALYs), disruptions of service provision in affected regions and problems with post-conflict health needs[31,32].

Afghanistan's history is typical of a fragile nation: in 2003, after decades of conflict, the country had terrible poverty rates, an infant mortality rate estimated at 165 per 1,000 live births, and an under five mortality rate estimated to be 257 per 1,000 live births – some of the highest rates in the world . In 2004, a Basic Package of Health Services was introduced by Afghanistan's Ministry of Public Health, and a balanced score card system was adopted to measure and manage the performance of health systems and services.The impact of this cycle of violence and poverty on health and health care is enormous. According to the World Bank's World Development Report 2011, no low-income fragile or conflict-affected country has yet achieved a single Millennium Development Goal.[33]

Ukraine was hit by shelling in July, which caused a gas explosion. For civilians in the war zones, few places are safe to hide. Following months of intense conflict, an increasingly alarming humanitarian situation is unfolding in eastern Ukraine. Hospitals have been shelled, tens of thousands of people are displaced from their homes, and thousands of casualties have been reported. "The health system in much of eastern Ukraine is bowing under the pressure of the conflict, with medical supplies drying up from treating so many war-wounded and the displaced.
The effects of the conflict are spreading even hospitals in neighboring areas outside the combat zones are struggling to cope, with many having already exhausted their budgets and supplies for 2014 ,leading to widespread communicable diseases affecting about 40% of the population, and

because of the sudden nature of the conflict means that people have suffered an acute sense of loss of their way of life, property, social and family networks.[34]

The ongoing conflict continues to hinder the human development of people in Syria. Young people have been particularly vulnerable, with half of all school-age children no longer in school and many schools closed due to violence, instability or damage. The health system is nearing collapse: 40 per cent of public hospitals are out of service and 63 per cent have been damaged, while over half of the 23 UNRWA health centres have been closed. Doctor-patient ratios have plummeted sixfold, even as more than 2 per cent of the population has been killed, maimed or wounded in the conflict.[34]

In Palestine,New tensions and clashes with unprecedented levels of violence and destruction have erupted in OPT. The month of May has brought a significant further deterioration of the humanitarian situation, especially in Gaza and Rafah. Between 1 and 25 May 2004, incursions by the Israeli Defense Force (IDF) into Gaza resulted in over 40 casualties and the total demolition of 202 buildings. 2,733 people have lost their homes and their belongings during this period. In various parts of Rafah, deliberate destruction of water and electricity infrastructure is threatening the health situation of the resident population in the absence of running water. The WHO warns of an acute threat of the outbreak and spreading of diseases in this context. Hundreds of homeless families and those fearing the destruction of their homes in the immediate future have sought refuge in several schools in Rafah. Sanitary conditions here are reportedly very poor and the risk of communicable diseases is rising from day to day.[35]

Civil war began in Southern Sudan in 1983 and conflict continued until the Comprehensive Peaceagreement was signed in January 2005 establishing home rule for the southern states under the Autonomous Government of Southern Sudan. However, some border areas were not resolve d by the peace agreement and fighting continued to displace people. The more than two decades of fighting has killed more than an estimated 2 million people, and another 4 million Southern Sudanesehave been internally displaced from the civil war, comprising one of the largest internal ly displaced populations in the world (IDMC April 2009). Conflict continues to displace people, and it is estimated that Southern Sudan had 390,133 newly internally displaced people from January to September 2009, which was twice as many, displaced in 2008.[36]Armed conflict and s ubsequent displacement and higher rates of infectious disease impact morechildren in Southern S udan, which is partly due to their larger population numbers. [36]

In recent years, West Africa has witnessed growing political unrest, armed conflict, civil war and riots. Côte d'Ivoire, the economic powerhouse of the West African Monetary Union (UMEOA), has suffered increasingly violent conflict, starting with a coup d'état towards the end of 1999 that proceeded to a full-fledged armed conflict in 2002.This tumultuous period left the country divided into a rebel-held North and a government-held South. The subsequent armed conflict left many research efforts in tatters , led to approximately 750,000 internally displaced persons (IDPs) and 500,000 refugees , caused a reduction in health staff of over 75% and an abandonment of health facilities of 80% .[37]

Post-conflict Sierra Leone still suffers from the effects of war. The 11-year conflict that ended in 2002 crumbled the health sector and fuelled social conflict and distrust of government. Not

onlydid a ‘perfect storm’ of multiple weaknesses crucially delay the response to the current Ebola outbreak, but post-conflict efforts to strengthen the health system and work towards providing equitable access to health care for all have suffered a devastating setback. The outbreak has heightened the lack of trust between service users and health service providers. People in remote areas of the country initially turned to traditional healers rather than health facilities, particularly in the early outbreak phase. This was also true for a few cases in the capital, Freetown. Fear of contracting the virus and high levels of mistrust have led both health workers and service users to abandon health facilities. Seeing their colleagues succumbing to the disease, ill-equipped health workers were understandably fearful of going to work.[38]

2.3 Health Service Delivery In Conflicts Situation

Essential to the well-being of all people are the effective delivery of basic services such ashealth, education, water and sanitation. Equally vital is freedom from the destructive and often Brutalizing impacts of violent conflict. Accessible, quality services contribute to theachievement of the Millennium Development Goals and to the achievement of human rights.

Widespread evidence shows that services are frequently failing poor people in a largenumber of countries, with negative impacts on human development outcomes. This isparticularly the case in countries and communities affected by various types of violent conflict.[39]

In addressing the failure of services, one key point is that the failure of services is not just technical, it is the result of the lack of accountability of public, private and non-profitorganizations to poor people. The failures of accountability are often connected with

distrust and alienation from governmental systems, so that reduction of conflict and improvement of services can work together to improve human security and human development. Thus, the processes of decentralization, shifting accountability for services to local authorities may contribute to a postconflict settlement and improved well being.[39]

As an increasing number of developing countries sustain strong economic growth and make progress towards the Millenium Development Goals (MDGs), the real challenge of development has shifted to “a group of countries at the bottom that arefalling behind, and often falling apart” These so-called fragile states lack either the political will or capacity to deliver public safety and basic services to all their citizens. In many cases, these states have suffered from many years of brutal civil war and genocide. While some have emerged onto a more positive development path, most continue to face very real risks of violence: from past grievances, pooreconomic prospects and new sources of conflict (such as organized crime, including drugs and trafficking, often linked to cross-border networks). Local, national and international approaches to violent conflict have to deal with this „dynamic reality, rather than simply assume a linear path from peace settlement to humanitarian aid and then reconstruction in „post-conflict countries.[40]

Conflict situations are characterized by war or civil strife in a country or area within a country. Affected populations may experience defined periods of violence (weeks to months), ongoing or recurrent insecurity in a protracted conflict (years to decades), or long-term consequences of a previous (usually prolonged) war. Conflict may lead to the displacement of large populations

into temporary settlements or camps with overcrowding and rudimentary shelters, inadequate safe water and sanitation, and increased exposure to disease vectors during the acute phase of the emergency.[40]

During the transition from conflict to peace, the limited health services that exist, mainly provided by humanitarian non-governmental organizations (NGOs), often come under threat of contraction. The most commonly cited reason is the so-called transitional funding gap, defined as a net reduction in monies available to the health sector during the transition from relief to development which may affect the delivery of health services. No studies to date have attempted to systematically analyse funding flows during transition, and the causes that contribute to this perceived gap.

In 2012, the ICRC launched the "Health Care in Danger" project that aims at improving the efficiency and delivery of effective and impartial health care in armed conflicts. The one-day seminar that took place at AU headquarters in Addis Ababa brought together under this framework 80 representatives of member States of the AU, The AU has recognized access to health care as a basic human right and has undertaken to play a leadership role in this regard through its commitment under Agenda 2063 and the Common African Position on the post-2015 Development Agenda, said the chairperson of the PRC Sub-Committee on Refugees, Returnees and IDPs, Ambassador Goncalves of Mozambique.[41]

Transmission of poliovirus was interrupted during conflicts in Cambodia, Colombia, El Salvador, Peru, the Philippines, and Sri Lanka. Efforts to achieve eradication in areas of conflict

have led to extra health benefits: equity in access to immunization, brought about because every child has to be reached; the revitalization and strengthening of routine immunization services through additional externally provided resources; and the establishment of disease surveillance systems. The goal of polio eradication by the end of 2000 remains attainable if supplementary immunization and surveillance can be accelerated in countries affected by conflict.[42]

The global initiative to eradicate poliomyelitis is focusing on a small number of countries in Africa (Angola, Democratic Republic of the Congo, Liberia, Sierra Leone, Somalia, Sudan) and Asia (Afghanistan, Tajikistan), where progress has been hindered by armed conflict. In these countries the disintegration of health systems and difficulties of access are major obstacles to the immunization and surveillance strategies necessary for polio eradication. In such circumstances, eradication requires special endeavours, such as the negotiationof ceasefires and truces and the winning of increased direct involvement by communities.[42]

In Palestine , United Nations relief and works agency for Palestine refugees (UNRWA) health services are an essential lifeline for Palestinians, providing primary health care and referral to secondary and tertiary services. During times of emergency, UNRWA health services are extended to all Palestinians in the Gaza Strip. On average, some 70 per cent of UNRWA health staff continued reporting to work, including at the height of hostilities, risking their lives and leaving their own families to provide health care to Palestinians in need of assistance. The commitment of UNRWA health staff to continue serving Palestinians even during the most difficult days of the conflict is highly commendable.[43]

Developing nations in the continent of Africa have been mostly cited in recent internal conflicts. Nations like Sierra Leone,Liberia, the Democratic republic of Congo, and most recently Darfur in Sudan have experienced internal conflict that have resulted in humanitarian crisis, and raised concerns throughout the globe. During these conflicts, acts such as killing, sexual violence, property looting, and abductions result in the death of millions, and the displacement of several more that flee to seek safety. Over the years, several international non-profit organizations such as medicine sans frontiers (MSF) have been actively involved in conflict ridden and post conflict regions, providing healthcare services and other forms of humanitarian aid to alleviate suffering, and improve the quality of lives of those affected. These organizations establish mobile clinics, counseling services, and other support resources to help address the healthcare needs of affected populations.[44]

2.4 Funding For Health In Conflict Situation

During the transition from conflict to peace, the limited health services that exist, mainly provided by humanitarian NGOs, often come under threat of contraction. This may partly be due to the fact that providers shift to a more sustainable, developmental approach. However, a reason more commonly cited is the so-called transitional funding gap, defined as a net reduction in monies available during transition for the health sector leading to reduced capacity to deliver health services. Transition is defined as when official overseas development aid (ODA) flows change from humanitarian to development funding lines. This change often influences the modalities and nature of health services delivered.[45]

A Study conducted In Afghanistan, revealed findings suggesting that there was no discernible gap in funding during the transition from humanitarian to development aid, and that development

aid now eclipses humanitarian aid five years since the end of the conflict. Political will and strong donor leadership were highlighted as key to the rapid scale up developmentfunding for basic services delivered through the contracting-out to NGOs.[45]

The European Union is the leading donor in the response to the Syria crisis with around 3.35 billion pounds of total budget mobilized by the commission and member state collectively in humanitarian,development,economic and stabilization assistance.The European commission is supporting partners to reach vulnerable people in need,providing amongst others: vital emergency food assistance, safe water,emergency medical supplies,shelter needs, protection, and cash and rent assistance. In 2014,the commissions totalhumanitarian budget for Syria crisis was 165 million pounds, in 2015,the commission has increase its humanitarian assistance to Syria by 136 million pounds,half of which will go to needs inside Syria accessing people both cross line from Damascus and cross border from neighbouring countries, and other half to Syrian refugees and host communities in neighbouring Lebanon,Jordan,Turkey and Iraq.[46]

In another study conducted in Democratic Republic of Congo suggest that there is a transition gap. A recent World Bank (WB) Public Expenditure Review revealed a steady increase in development funds from 2003 – 2007 but a marked decline in humanitarian funding which has led to a transitional funding gap. An 80% decline in humanitarian funding (2006-07) has resulted in abrupt withdrawal of humanitarian NGOs and thus reduced health service delivery. DRC's complex aid instruments coupled with donor geographic stratification also challenge coverage

and coordinated approaches to health service delivery; currently an estimated 83/515 health zones have zero external support.[47]

In Sierra Leone, it is not possible to determine if there was a transitional funding gap due to the difficulty of obtaining reliable information. Sierra Leone has witnessed downsizing of humanitarian support to health services following the peace agreement in 2002, while key informants report that development funds are slow to arrive. The exit of a number of international NGO's due to unavailability of funding suggests that there may have been a funding gap.[48]

In South Sudan, it has not been possible to obtain comprehensive funding trends, however delays in the disbursement of the Multi-donor Trust Fund (MDTF), which accounts for 43% of total funding, are strongly indicative of a funding gap, as confirmed by NGOs. To fill the gap, donors such as OFDA, which supports over 50% of health services currently provided to NGOs, have extended humanitarian aid to try to sustain services for rural populations. Efforts to augment humanitarian funding were also initiated by donors such as DFID through its Basic Services Fund and by UNDP through its recovery and rehabilitation program.[48]

In Timor Leste, it was ascertained that there was no transitional funding gap affecting the delivery of health services after the conflict. A 2005 Mid Term Expenditure Framework (MTEF) revealed that the total funding to the health sector had been increasing over the past ten years. While a reduction in donor aid was anticipated, government funds were expected to increase due to East Timor's available oil revenues.[49]

Finally, in Liberia, aid flow information revealed that there was no transitional funding gap. There was a very strong threat that it would occur in 2006 as humanitarian donors were starting to leave the country, and development funding was slow to arrive. However, due to the recognition by both the Ministry and the NGOs that this was about to occur, pressure was put on the donors at the Washington Donor's Conference in Feb 2007, and the gap was averted as humanitarian donors agreed to continue to fund basic health services until the situation stabilized.[50]

In conclusion, there are numerous reasons why the transition from humanitarian to development ODA differs, with some situations seeing a smooth transition, and others experiencing more unpredictable funding. Reasons include technical issues such as the aid mechanisms that are used. More political reasons include predictability of aid, donor behaviour and policies towards various post-conflict settings, and ability to harmonize with, and align to national governments. Government capacity and legitimacy was also identified as determining the inflow of development ODA, and the outflow of humanitarian aid. Finally, NGOs, who can be substantial funders in their own right, may decide to exit a post-conflict situation, leaving a gap in funding and services[50].

2.5 Role Of Ngos And Developmental Partners

NGOs participate in a wide spectrum of health-related activities during humanitarian emergencies and in general have significant capacity. When working with UN agencies and IOs, NGOs serve as the front-line combatant against epidemics, large-scale malnutrition, and ultimately high mortality rates. It is essential to understand that some NGOs specialize in health care, and some do not and that NGOs normally do not work alone in the health sector. Coordination within and outside he NGO community is considerable.[51] UN agencies like the World Health Organization (WHO), Pan American Health Organization (PAHO), UNHCR and UNICEF, for example, are all key leaders and partners in assisting NGOs with their missions and capabilities particularly in health. NGOs provide ground- level information about health needs of displaced and nondisplaced populations, and are also the implementing agent for health programs. WHO and UNICEF, meanwhile, are often the backbone of support for shipments, surveillance, comprehensive data compilation, guidelines, and technical services. The health sector incorporates a large swath of sectoral activities. NGOs are often, as mentioned, the first actors into an emergency setting and just as often the last to leave. NGOs provide valuable ground-level information for the international community as well as the ground-level implementation of health services. [51]

Due to the fact that NGOs are so often either first on the ground in an emergency or active in the health sector in a region beforehand, they are often best suited to respond. Once an emergency

hits, the NGO community can normally collect assessment data, surveillance systems, and program proposals before other organizations can gear up. Once the international community and larger agencies (UN, government) are ready to begin implementing or funding programs, the NGO community serves as an orienting body or partner for creating a comprehensive, emergency-wide health program. NGOs report to the international community and then implement programs with financial and technical support from organizations and donors such as WHO, UNICEF.[51]

NGOs are thus by far not the only operating agencies in the health sector during an emergency. UNICEF, CDC, OFDA and DART teams, the World Food Program, and other larger agencies often have operational wings that can implement programs just as NGOs do (and sometimes with larger scale or technical capacity). Still, NGOs provide the bulk of emergency health programming and are normally the implementing agents for donor and coordinating agencies.[52]

Non-governmental organizations (NGOs) have been defined by the World Bank as 'private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services, or undertake community development'. NGO activities can be local, national or international. NGOs have contributed to the development of communities around the world and are important partners of many governments – while remaining independent from governments.[52]

The Fourth International Metropolis Conference was held in Washington D.C. from December 8-11,1999 at Georgetown University's Conference Centre. The themes of the Conference were :

Building Community (Civil Society and Citizenship), Neighbourhood Development (Housing and Labour Markets), Governments and NGOs in Partnership. Canada's medical surveillance program requires that entrants placed under surveillance report to a public health authority within thirty (30) days of entry to Canada. This process is potentially beneficial to both the entrant as well as Canadian residents. For entrants who speak neither of Canada's official languages this can pose quite a challenge. The involvement of NGOs is seen as a possible way of making this process easier for the entrant as well as ensuring high compliance.[53]

NGOs play a signiﬁcant role in PHC provision in rural Bangladesh during crisis, and they provide most of these services in urban areas. Several hundred indigenous NGOs have been active in health and development since the country's independence in 1971, Under the Government of Bangladesh's 5-year Health and Population Sector Programme (HPSP), the overall objective was to improve the health and population status of the least advantaged, particularly women, children and the poor. This was to be achieved through concentration of resources on client-centred provision of an Essential Services Package (ESP), consisting of reproductive and child health services, communicable disease control, limited curative care, and behaviour change communication. The government recognized that this would require an effective sector-wide partnership with NGOs.[54]

In a study conducted in Pakistan on NGOs and government partnership for health systems strengthening it was concluded that since Public sector in Pakistan has been deficient in the capacity to deliver equitable and quality health services and thus has been grossly underutilized

International and local non-governmental organizations (NGOs) have endeavored to fill the gaps in health service delivery, research and advocacy. NGOs have relatively performed better and achieved the results because of the flexible planning and the ability to design population based projects on health education, health promotion, social marketing, community development and advocacy.[55]

After the civil war in East Timor (1975-2001), a government-led district health system was established by the government, international agencies and NGOs. A long term plan was developed based on consensus among all actors and was carried out mainly by NGOs for the first period of time. In 2002, the government was handed over full responsibility .The standardization of health services and provision of the same basic package of care throughout the country improved the geographic equality and health care in general, showing that a good national coordination of aid and health care provides sufficient health care to everyone. Legitimacy of the system, trust by external actors, small size of the country and social cohesion in the state were favourable conditions to accomplish this success.[56]

Decentralization has become one of the key features of Indonesia's democratization process

since 1999. Indonesia has shifted more authority and resources from central government to

local government, especially to the district and municipality levels. As a consequence, subnational government was managing half of total public investment by 2003 . This policy should bring the government closer to the people and make it more responsive and accountable

to citizens' demands. However, continual pressure from local civil society, especially non-governmental organizations (NGOs) and the local mass media, for improvements in basic service delivery are also Important, The alliance between NGOs and the local mass media to promote responsive health care services in Makassar municipality, South Sulawesi province, is one example of effective partnerships among civil society entities.[57]

Healthcare delivery in Ghana is mainly a preserve of the public sector. For many years, private organizations and NGO's have not been encouraged to help improve healthcare delivery and improve accessibility to healthcare services all over Ghana. Beginning in the year 2000, the Ministry of Health recognized the pivotal role NGO's can play in improving quality healthcare accessibility and education , leading to formation of Ghana Coalition of NGO's in health which was involves in execution of many health programmes such as , An institutional development and capacity-building project funded by the Royal Netherlands embassy, aimed at increasing the capabilities of member NGO's to provide healthcare services for residents in the rural communities of Ghana, A Ghana Aids Commission funded project targeted at 5 districts in the Eastern Region of Ghana. This project is aimed at reducing the rate of new HIV infections in the region. This project aims at educating residents on the dangers of HIV/AIDS, while encouraging testing and control, A UNAIDS funded project to infuse anti-stigma messages in outreach programmes all over Ghana.[58]

In Rwanda UNFPA, UNICEF and UN Women, in collaboration with women's NGOs and community representatives, developed a Joint Programme on VAW including the establishment

of One Stop Centers providing holistic care to GBV survivors and the creation of GBV and Child Protection Committees at grassroots and national levels. A community policing system is in place, coupled with the installation of toll-free hotlines and gender desks in police, army and prosecutor offices. As a result of the sector-wide engagement, in which all manner of NGOs played a critical role, a new law preventing and punishing GBV was adopted in 2009.[59]

In Ethiopia, UNFPA partnered with NGOs (including FBOs and the Orthodox clergy), to advocate against child marriages. Leveraging the joint outreach and power of the government and civil society resulted in a mass awareness-raising campaign which continues to impact on perceptions and behaviours, and is witnessing a steady increase in the number of young girls now attending schools.[59]

In Nigeria, the public private mix and NGO as outline in the National Health policy strongly recommends and increased role for the private sector and other development partners in service delivery,the policy permits the participation of the private for profit and not-for-profit including health providers, religious and other voluntary organisations, communal bodies and individuals in the provision and financing of health care services. It has however been deduced that one of the key factors responsible for the unsatisfactory National health status is weak and ineffective coordination of the numerous stake-holders and active participants in the health sector.[60]

2.6 Strenthening Health System In Conflict/Emergency Situation

The international community has compelling humanitarian, political, security and economic

Reasons to engage in rebuilding and strengthening health systems in fragile states. Improvements

in health services and systems help to strengthen civil society and to restore legitimacy to governments. Effective engagement with fragile states to inform the design of health programmes and selection of interventions depends on donor coordination and an understanding of health system challenges.[61]

Over the past few years, fragile states have come to the forefront of the concerns of bilateral and multilateral development agencies. The result has been an increase in resources, attempts to target better the use of resources, and efforts to deal with the consequences of a lack of coordination or long-term commitment to the process needed to ‘fix’ fragile states. The health of such states, their people, and their health systems depends in large part on meeting urgent health needs, carrying out quick-impact and medium-term responses, as well as addressing the longer-term development and strengthening of health systems.[61]

What is a fragile state? Although there are many descriptions of fragile states, the two criteria on which they are judged are legitimacy government will and capacity to provide core services and basic security and effectiveness in providing services and security. Legitimacy is the determination and ability of government to work in the interest of the public and to demonstrate fairness to all groups. Effectiveness means the ability of government to maintain security and order and to provide public goods and services to citizens. These elements are interrelated because the lack of capacity or willingness of governments to respond to people’s basic needs

food, health, sanitation, security, shelter and water—means that people feel betrayed by government ineffectiveness.[61]

In 2004, the High-Level Forum (HLF) on the health MDGs brought together the World Bank, the World Health Organization (WHO), bilateral donors, and ministers of health and finance, to discuss how to achieve the health MDGs. The HLF identified fragile states as a key topic of interest, and produced several seminal papers. Overall, it was found that, similar to lower-income countries, there is a need to strengthen the health systems in fragile states if they are to accelerate progress against the MDGs.[62]

In conflict-affected fragile states, delivery and scaling up of health services is more difficult than

Other low-income settings due to poorer governance, and severe human resource and financial constraints. For example, by the end of the war in Liberia, there were fewer than fifteen physicians left, and 80% of the health services were provided by nongovernmental and faith-based organizations. Resource constraints are further exacerbated both by a contested policy

environment and a reliance on international aid, which results in extremely volatile funding. It also makes harmonization and alignment more challenging to the detriment of aid effectiveness. It is thus difficult, and sometimes inappropriate, to apply lessons and recommendations from low-income countries to conflict-affected fragile states.[62]

On the 11th October 2012, the Medicus Mundi International Network organised a one day expert meeting, hosted by Cordaid and the Royal Tropical Institute in Amsterdam, on the theme of 'Health Systems Strengthening and Conflict Transformation in Fragile States'. The meeting brought together approximately ninety MMI members and representatives of a range of NGOs

and academic institutions. The purpose of the meeting was to explore if it is possible to strengthen health systems and address fragility at the same time.[62] The various conflicts in Central America in the 80's and the former Yugoslavia in the 90's led to elaboration of the concept of Health as a Bridge to Peace and was even formally accepted by the World Health Assembly as a 'multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and postconflict situations and at the same time contributes to peace-building'. By and large, it proved difficult to operationalise the concept and there was the critique that activities may place health in the political, peace-building sphere, thereby politicising health.[63]

In response to the humanitarian crises in fragile, post-conflict states, the international community has mobilized to provide assistance. In the health sector, post-conflict assistance focuses on three targets of intervention that are broadly sequential these include , Meeting the immediate health needs of conflictaffected populations, Restoring essential health services, and Rehabilitating the health system.[64]

Meeting immediate health needs falls at the core of humanitarian and complex emergency crisis response and international NGOs are at the forefront around the world, in some cases providing services while conflict is still underway, not simply following cessation of violence. As experience in Liberia, Mozambique, Sierra Leone, and Timor Leste demonstrates, interventions call for rapid ramp-up, urgent infusion of resources and capacity, and concrete results, as the

provision of health (along with other services) is one of the critical demonstrations of the transition to peace.[64]

Due to Ebola crisis in the African countries, an Emergency Ebola Response workshop was convened Nov. 5-7, 2014, in Washington, DC. The workshop participants were leading anthropologists who have dedicated their professional lives to understanding the societies and people of Liberia, Sierra Leone, and Guinea. Among professionals, anthropologists are well positioned to make a vital difference in stopping Ebola.[65] These anthropologists have lived in these countries, researching and documenting societal and family structures, lines of respect and authority, spiritual beliefs, the region's distinct subcultures, mobility patterns tied to agriculture and seasonal changes, the impact of decades of war and poverty, and the history with former colonial powers that make many West Africans countries of trusting international help even in a crisis of this proportion.[65] The current Liberian and Sierra Leonean health sectors were built just 12-15 years ago and were created by the international community. In other to strenthen their health system they use a model which assumes epidemics are endemic and local urban and rural resources remain underdeveloped. As a result, in moments of crisis, enormous expenditures are needed to address health problems. A shift needs to occur that will promote an expanded health sector, greater stability, and long-term solutions. System strengthening should focus on improvements in health information systems, workforce training and development, facilities, equipment and supplies, and in the areas of planning and resource allocation decision-making.[65]

Sub-Saharan Africa is lagging behind in achieving the United Nations Millennium development goals particularly those which are directly health related. Although there have been some level of commitments with improvements on many fronts; however, the divide still remains in the region where the issues of high child and maternal mortality, under nutrition, human rights violation and overall weak health systems still continue to pervade.[66] This bothers on the poor state of health of many of its citizens which is further exacerbated by the harrowing conditions of health care delivery and the health systems in general. While the region lags behind, this doesn't give the overall global reflections as there have been tremendous achievements in health and health care. Significant strides in epidemiology, population health and health systems have addressed most of the challenges of communicable diseases and these matched with technological inputs have met the basic health needs of humans and accelerated health care delivery.[66] More so, scientific breakthrough in agriculture has also helped to tackle the challenges of hunger and under nutrition globally. These trends in a nut shell have improved on the health and overall developmental indices of humans globally. However, sub-Saharan Africa needs to be at par with the rest of the World if the MDGs are anything to go by. It is these that necessitate the need for an accelerated empowerment to strengthen the existing weak health systems in the region.[66]

2.7 Human Resource System In Conflict/Emergency Situation

Human Resources for Health (HRH) is a priority issue and constitute the most important resource of the health system as the Health system is labour-intensive. HRH accounts for a substantial proportion of the health sector expenditure - 80% recurrent Budget in most countries. This has therefore become more imperative for African countries under conflict situation where

efforts are being made by the Government and the health sector to improve the health status of their people after a long period of conflict .[67] According to WHO (2005), although much has been written on the different aspects of pos-conflict reconstruction of Health Services, little attention has been given to the effects of conflicts on the Health workforce and its implications on post-reconstruction of Health services. In recent years despite increasing recognition of the importance of HRH, and the participation of many agencies in the post-conflict reconstruction of countries, approaches and inputs have rarely been documented. As a result, there has been virtually no use or dissemination of lessons learnt leading to perpetuation of ineffective approaches and missed opportunities to effect change.[67] In spite of the foregoing, the Health sector of Liberia is trying to provide essential health care that is affordable and accessible to families and communities in line with Millennium Development Goals following from the Health–for-All policy for the 21st century in the Africa Region: Agenda 2020, in the 1978 Alma Ata declaration. In this direction, rehabilitations, expansions and establishment of old and new health facilities to cater for the health needs of its people, in the wake of its declining economic and human resources are on-going.[67]

In the last few decades, Iraq's health care capacity has been severely undermined by the effects of different wars, international sanctions, sectarian violence and political instability. In the aftermath of the 2003 US-led invasion, the Ministry of Health has set plans to expand health service delivery, by reorienting the public sector towards primary health care and attributing a larger role to the private sector for hospital care,[68]and the iraq ministry of health in collaboration with developmental partners made Human Resources for Health (HRH) as a priority issue and

constitute the most important resource of the health system as the Health system is labour-intensive. HRH accounts for a substantial proportion of the health sector expenditure .[68]

Human Resources for Health Development (HRD) has been a priority and focus of attention in the Palestinian healthcare system since the changeover of authority on the system at the end of 1994.A study conducted analysed and examines HRD between 1994 and 2001, which provide an insight into and better understanding of the issue in a conflicting and transitional context. The results of this analysis are presented in two parts. Part I looks at the current situation and recent developments in Human Resources for Health (HRH) in Palestine.[69] On the one hand, it analyses the relationship between HRH deficiencies and major policy options and strategies. On the other hand, it examines the correlation between HRH policy development and the policy context and Particular attention is given to the links between national health policy priorities and health sector reform initiatives. Part II focuses on the process of HRH policy formulation and implementation in the crisis situation.[69]

Despite constraints facing the health system in Afghanistan, the country is implementing strategies to boost human resources for health (HRH). A report recently showed that the quality of health service has improved by 25% in the last five years, and a number of policies and plans exist to address a range of issues within the health system.[70] A human resources observatory was established in January 2010 and strategies to address workforce challenges are in progress. The Ministry of Public Health and the Ministry of HigherEducation established a joint committee to address HRH training issues such as curriculum content, standards, accreditation, new courses,

and selection criteria for students. A Reform Implementation Management unit was created within the MoPH, resulting in refining of the mission, staff requirements.[70]

One fundamental weakness in many Sub-Saharan African (SSA) countries is the inadequacy of human resources for health (HRH), which form the foundation of health services delivery. This inadequacy can include a general lack of the availability of key skills within the health system, the mal-distribution of health workers according to the health needs of regions or districts within the country, or the presence of "ghost workers" within the system.[71]The Liberian health system suffers from a low ratio of physicians, nurses and midwives per population as a result of instability (political conflict). The MOHSW aims to have 70 percent of its facilities in each county providing the Human Resources for Health (HRH) by December 2010, which includes a minimum of a certain number and types of health workers stationed at the facilities. Furthermore, the MOHSW intends to increase its current health workforce of around 4000 to about 6000-8000 by 2015 (MoH 2009).[71]

The civil war in Sierra Leone (1991-2002) killed tens of thousands of people, displaced nearly a third of the population and had a sustained negative impact on population health .Only 31per cent of births are attended by a trained health professional and women in urban areas are twice as likely to have a health professional present during delivery as their rural counterparts.Today, key challenges to accessible health services and better health in Sierra Leone include ,an acute shortage of trained health professionals ,a significant dichotomy of staff between rural and urban facilities and among professional cadres and poor access to high quality care, medical technology and equipment.[72]

South Sudan is slowly emerging from over twenty years of civil war and decades of political and social instability. One of the most disheartening results of the conflict can be found in the country's extremely poor health indicators. The conflict left one third of the country's 8 to 12 million people without access to adequate health services, completing the transition from an already weak health system to one in complete ruins.[73]

An acute lack of human resources for health is consistently raised as the most critical issue facing South Sudan health worker density is substantially less than one per 1000 population . In 2006, statistics from the Ministry of Health (MoH) estimated a total workforce of around 11,800 . Although the country has since witnessed the return of many health professionals, there is concern that these workers are in jeopardy of burning out if the human resource base is not expanded quickly. [73]

Zimbabwe, once renowned in the Sub Saharan region for providing high quality, accessible and affordable health care services to its populace, is now facing a challenge in attracting and retaining qualified health personnel. The effects of the increased burden of disease and the high demand for services as well as low staff motivation have worsened the situation. Without a well trained and motivated health workforce it will be difficult to provide health care services to the standards required.[74]

Nurses and midwives represent the majority of primary health care workers in Zimbabwe and they greatly outnumber physicians.While nurses constitute 46 per cent of the primary health workforce and midwives 19 per cent, physicians represent only 7 per cent. Although improvements have been made with regards to nurse/midwife staffing increases, nearly 51 per cent of physician positions and 10 per cent of nursing/midwifery positions remained vacant as of 2010. Even if all established MoHCW positions for doctors, nurses and midwives were filled in Zimbabwe, health care worker density would still be only 1.65 per 1000 population, well short of the WHO recommended 2.28 per 1000 population. [74]

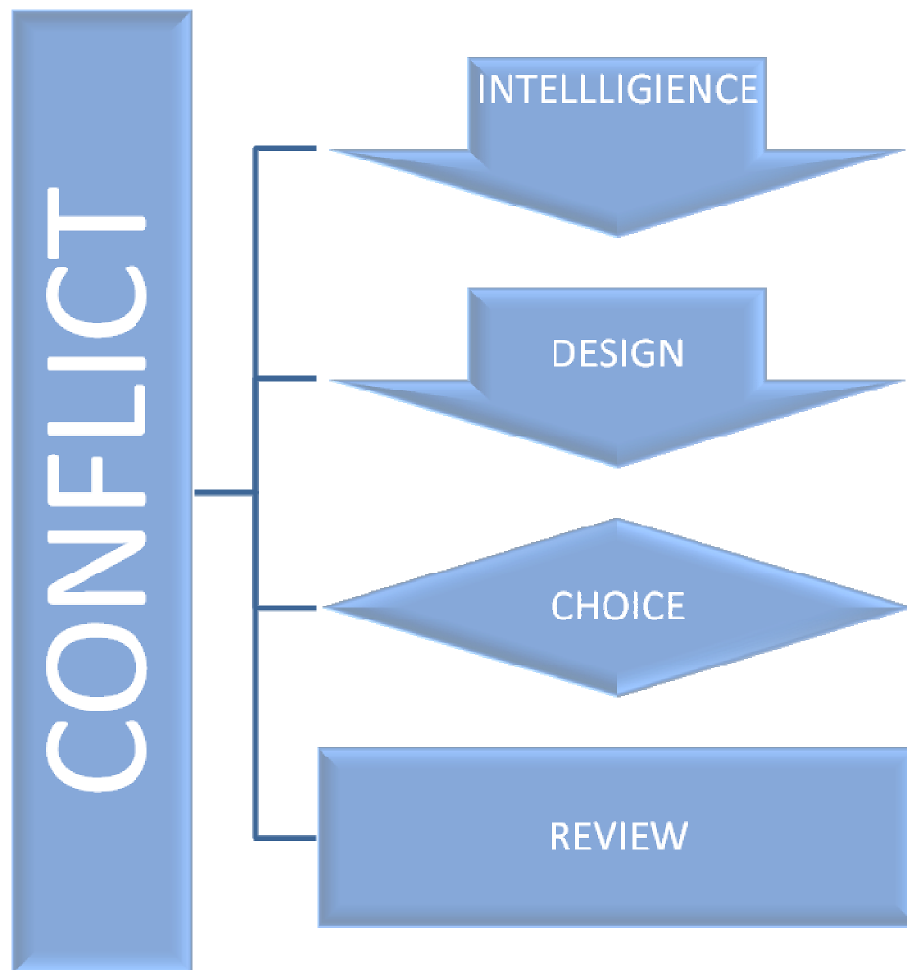
2.8: CONCEPTUAL FRAMEWORK

There are various model/theories explaining decision making process .The choice of a model however is dependent on condition or situation it is intended to be used for. Majority of the theories are based upon categorization provided by Keen and Scott morton , Huber and Das and Teng .[36] This include rational comprehensive model, model of bounded rationality, incremental theory, organizational view, political view, garbage can model etc.

For the purpose of assessing priority setting in Yobe State where there is emergence of insurgenciesfrom Boko Haram attacks, deterioration ofhealth services and funding for health, making (Rational comprehensive model) is adjudged appropriate. The model consists of four basic steps as proposed by Simon,[76]these including: Intelligence,Design,Choice and Review as shown in figure 1 blow.

Fig:

1



Four steps of decision making process.

The manager/decision makers collect relevant information about the problem, analysed the information, evaluate it, make their final choice about the problem, then finally review the whole problem and later make their final decision by prioritising the health care problems.

During the process it was assumed that the decision makers has exploited all the possible

alternatives in the choice phase, the consequences of implementing each alternative, have a well organized set of preferences for these consequences, have computational ability to compare consequences and to determine which is prefered, then, they will be able to make effective decision about the health care problems and prioritized it.

The process of making decision is a complex and interelated steps by managers/decision makers. This process becomes even more complex when it involves decision about conflict situation. The managers or decision makers would first of all collect all the relevant information about the problem or conflict, this would be analysed, evaluated and then make a decision.

According to the theoretical frame work, conflict is directly or indirectly related to the level of intelligence, the design, choice of the decision and finally the review of the decision.

The ability to make an effective decision regarding selecting a priority health problems is also dependent on all these interelated factors in the conceptual frame work and this need a comprehensive review for future decision.

CHAPTER 3

METHODOLOGY

3.1 Study Area

Yobe State was created along with other Nine States in the federation on 27th August 1991, the area was noted for its expenses of harsh terrain to the Northern part characterised by desert encroachment and Sahel to the South.

Yobe State had seventeen Local Government Areas with a total population of about 1.4 million people in 1991. The state has a land area of 47,153 square kilometres; it is located between latitudes 10:5^{0}N and 13^{0}N. it shares common political boundaries with Jigawa and Bauchi States to the East and North and Gombe State to the South respectively. It also shares an international political border of 323km along with Republic of Niger to the North.[77]

TOPOGRAPHY

Yobe State has a flat terrain to the South West, Scattered rugged hills to the South and South East around five Local Governments areas, and to the extreme Northern parts harbour several kilometres of harsh expense of undulating sand dunes made from consequence of desert encroachment covering parts of Machina, Karasuwa, Yusufari, Yunusari and Bade Local Government areas, and to the eastern and western parts of the state covering about seven Local Government areas land is flat with sparse and fairly grown vegetation intermixed with trees of a cassia, tamarind, locust beans and Shea butter.

River Yobe is a prominent geographical feature of the state, which flows through five local government areas before emptying into Lake Chad; other popular rivers include Anumma, Katarko, Hadejia, KumaduguGana etc.[77]

CLIMATE

Yobe State has wide range of variability in climate, which made it unique from other states in the country. It has not cold, dry and rating seasons in the year. The dry season lasts for more than seven months in a year,while the rainy season is short. The hottest periods of the year are between March and part of June with temperatures recording over 40^0C. Rainfall lasts between 120 to 140 days with annual drops ranging between 500mm to 1000mm depending on the location. Between December and February is the period of Harmattan which is characterised by cold, dry, dusty and foggy winds.

The vegetation in Yobe State is characterised by its unique semi-amid to the south and aid conditions to the North, which are associated with Sudan and Sahel Savannah and shrub vegetation to the extreme Northern parts of the state. In the scattered rugged hills of Gulani, Fika and Fune Local Governments areas is the Montana vegetation.[78]

YOBE STATE HEALTH SYSTEM

The Yobe Health sector was carved from the Borno State Ministry of Health in 1991 on the creation of the state. Then, it was the State Ministry of Health and the Hospitals Management board. The PHC system was under the LGAs. The SMOH had zonaloffices. The Ministry is

headed by the Honorable Commissioner who is the political appointee. The accounting officer was then the Director General of the ministry later renamed the Permanent Secretary. The HMB was headed by the Executive Secretary, later Executive Chairman. NowExecutive Secretary as at 2015. In 2009, the State Agency for the control of HIV/AIDS was created backed by law, earlier was an action committee on AIDS. In 2012 after about a year or two painting process, the bill establishing the State Primary Health Care Management board was created. SACA is headed by an Executive Director who doubles as the Program Manager for the World Bank HIV response project. The PHC was headed by a Director General until last year position changed to Executive Secretary. The PHC has six area offices. All LGA health departments have been ceded to the board including all PHC, CHCs structure and staff in line with Primary Health Care under One Roof principle. LGA health team headed by the Chief health officer. Then calledPHCCoordinator.[78]

SMOH has depts of Public Health, Medical and Dental Services, Pharmaceutical Services, Planning Research and Statistics, Nursing Services, Human Resources, Finance and Supply, Traditional Medicine. Headed by Directors. HMB has Medical services, Nursing, Pharmacy, Lab services, Personnel and finance. SPHCMB has PHC, Procurement, supplies and Pharmaceuticals, Finance, SMOH Policy, HMB has 12 Secondary, 2 tertiary facilities and PHCMB takes care of the primary level of care and disease control programs.

The state has been facing security challenges since 2010 with persistent attacks by insurgents called Boko Haram. With the exception of Machina, Karasuwa and Nguru, all the LGAs

experienced sporadic insurgency attacks; the worst areas affected were Gujba and Gulani LGAs. Thousands of people lost their lives and many Houses, Mosques, Churches, private and government establishments were burnt and destroyed by the insurgents. These led to internally displaced population of over 116,595 living in host communities and about 11,600 IDPs camped in four (5) locations within the state[78] (source: State Emergency Management Agency-SEMA).

OBJECTIVES OF SETTING THE CAMPS:

1. To settle the IDPs in a spacious and secured environment
2. To provide shelter, food, water and sanitation to the IDPs in the camp
3. To prevent outbreak of diseases in the established camp
4. To identify and treat any illness among the IDPs in the camp
5. To ensure security of lives and properties of the IDPs in the camp
6. To rehabilitate them from the psychic traumas of the attack
7. To plan and facilitate their return/relocation

3.2 Study Design

A cross-sectional descriptive study designwith mixed method of data collection among internally displaced persons (IDPs) and members of the communities.

3.3 Study Population

The study has three different major categories of respondants, these include

1. Decision makers in the ministry of health, Agriculture, Education, Local Government and Chieftaincy Affairs, Budget and Economic Planing, NEMA/ SEMA
2. Healthcare workers in the state Specialist hospital and IDP Camps

3. Internally displaced persons living either with the relatives or in the IDP Camps.

3.3.1: Decision Makers

This comprises the key decision makers in health and health related ministries.These include:

1. StateMinistry of Health(SMOH)
    - Director Public Health
    - Director Personnel Management
    - Director Finance and Supply
    - Director Planning,Research and Statistics
    - Director Medical Services
    - Epidemiologist-State
    - Control officers for TB and Leprsy, HIV/AIDS, Rold Back Malaria.
2. State primary health care board(SPHCB)
    - Director Primary Health Care
    - State immunisation officer
    - Maternal and Child Health Programme officer
    - Health education officer
    - State Monitoring and Evaluation officer
3. Ministry of Local Government and Chieftaincy affairs(MLGCA)
    - Permanant Secretary
    - Director Finance and Supply
    - Director PHC
    - Director Budget and planning

- Director Joint Account

4. Ministry of budget andEconomic planning(MBEP)
   - Director Budget
   - Director finance and supply
5. State Hospital Management Board(SHMB)
   - Executive Chairman
   - Director Medical Services
   - Director Nursing Services
   - Director Finance and Supply
6. Ministry of Agriculture
   - Permanent Secretary
   - Nutrition Officer
   - Director Budget and planning
7. Ministry of Education
   - Permanent Secretary
   - Education Officer
   - Director Budget and Planning
8. State National Emergency Management Agency(NEMA)
   - State coordinator
9. Traditional Medicine Board
   - Executive secretary

3.3.2: Health workers

Study population:

All the health workers in the IDP Camps health facility and specialist hospital Damaturu

3.3.3: Internally Displaced person(IDPs)

Study population

All the Internally Displaced person(IDPs) in the IDPs camp

3.4.1 Inclusion Criteria

Key decision makers in the affected ministries and board and members of the community (including IDPs)

3.4.2 Exclusion Criteria

Those that refused consent to participate in the study among the key decision makers and members of the community/IDPs

3.4 Sample Size Determination

3.4.1 Decision Makers

All the stakeholders in health and health related ministries

3.4.2 Health workers

Since the number of the health workers is not large enough to allow sampling, i decided to study all the health workers in the IDP Camps and specialist hospital

Number of health workers in each health facility

1. Gwange clinic = 15
2. Nayinawa clinic = 12
3. Family support clinic = 20
4. Specialist clinic = 24
5. Maisandari clinic = 9
6. Pompamari clinic = 10
7. Kasesa clinic = 10
8. Kukaraita clinic = 09

Total number of Health workers = 108

3.4.3: Internally Displaced person(IDPs)

Sample Size Determination:

(b.) The minimum sample size requiredwasestimatedusing the Fishers formula:[80]

$n = Z\alpha^2 pq / d^2$

Where n = Minimum sample size required

$Z\alpha$ = the standard normal deviatecorresponding to 5% level of significance. The Valueobtainedfrom the normal distribution table is 1.96.

p = proportion of patients satisfied with service received from AKTH = 83%= 0.83 (obtainedfrom a previousstudy) [81]

q = complimentary probability of 'p' = 1-p = 1- 0.83 = 0.17

d^2 = precision of the study = 0.05

$$n = \frac{(1.96)^2\{0.83 \text{ X } 0.17)}{(0.05)^2}$$

n =216.82 =217.

To account for non-response and other contingencies, the sample size wasincreased by 5% and rounded up to 228.

From the result obtained above, 228 people from the community will be recruited for the purpose of the research.

3.5 Sampling Technique

3.5.1 Stakeholders

Since the total number of the key stakeholders is not large enough to allow sampling i decided to study all the stakeholders

3.5.2 Health care workers

Sincethe total number of the Health care workers is not large enough to allow sampling i decided to study all the health workers in the IDP Health facilities.

3.5.3 Internally displaced persons (IDPs)

The sampling technique use was multistagesampling.

Non probability sampling method was used i.e(purposive sampling technique) to select Damaturu LGA,this is because all the IDPs camp were situated within the local Government.

First stage: Selection of political ward, Damaturu LGA consist of 10 political wards,5 out of 10 wards were selected (purposive sampling), because all the IDPs and key stakeholders were living within Damaturu LGA(METTOPOLITANT).

Second stage: All the health facilities were studied in the 5 political wards (has only 8 health facilities in which all the 7 health facilities were selected(7 IDP Clinics , 1 specialist Hospitals a) because they serve all the community and IDPs .

Third stage: selection of the respondent at eachhealth facilities

Allocation proportionate to size were used to determine the number of respondent to be drawn from each health facilities i.e The total number of the client were obtained from each health facilities per month through patient attendant Register, then the proportion was obtained by dividing the total number obtained from each health facility per month by the total number of patient attending all the health facility in Damaturu LGA and multiply it with sample size (x/y x Sample size).

Proportionate allocation of the respondent of eachhealth selected facility

a. Pompamari IDP Clinic : 100 / 492 x 228 = 46.0
b. Kasesa IDP Clinic : 60 / 492 x 228 = 28.0
c. Kukareta IDP Clinic : 42 / 492 x 228 = 20.0
d. Gwange PHC : 32 / 492 x 228 = 15.0
e. Nayinawa PHC : 30 / 492 x 228 = 14.0
f. FSP PHC : 50 / 492 x 228 = 23.0
g. Maisandari PHC : 28 / 492 x 228 = 13.0
h. Specialist Hospital : 150 / 492 x 228 = 70.0

3.6 Procedure for Data Collection

3.6.1Training of interviewers/Research assistant

Six adolescents (3 males and 3 females) who have completed secondary school education were recruited as research assistants to assist in the data collection process. Female interviewers interviewed the female respondent while the male interviewers interviewed the male respondent. A three days training wasconducted by me for the interviewers. The training includedreadingthrough the questionnaires, understanding the questions and standardization of Hausa language translations of certain termsthatmaybenecessary in the research and the assent process. Emphasiswas laid on ensuringthat the questions werefilled and labeledlegibly.

3.6.2 Study Instrument

The instrument that was used for data collection include In-depth interview guide for interview with heads and programme officers for State Ministry of Health and Health related Ministries and a Questionnaire for exit interview with consumers of health care.

(a) In-depth Interview - In-depth interviews were conducted with the key decision makers across health and health related ministries and boards i.e. among the commissioners, directors, executive secretaries of the boards, and information on health prioritisation was collected using tape recorder then later transcribed and triangulated with Quantitative Data.25 IDIs was conducted.

(b) The quantitative data collectionwere carried out using the pre-tested interview administered questionnaire to collect information from the Health care consumer(IDPs) and Health workers , and was adapted from the type developed by the clinical Quality service branch of the Bureau of Primary Health Care (BPHC) in the United states of America.[90]

We have two questionnaires one for the health workers and the second one is for the IDPs(exit interviews).

3.6.2 Study Procedure - Advocacy visit were paid to the key stakeholders of the health and health related ministries and boards and an indepth inteviews were conducted with the stakeholders where useful information were recorded (Audio recording) and then transcribed/ analysed along the thematic areas on the subject matter. Using questionnaire an interviews were conducted with health personnels delivering the health services and the communities (IDPs) and hence data on health facilities and IDPs were collected and analysed.

3.7 Data Analysis/ Data Management

Collected data were entered into a personal computer and cleaned using Microsoft Excel spreadsheet. Analysis was done using SPSS statistical software version 21.

Quantitative variables were summarised using Mean and Standard deviation or Median and Inter quartile Range as appropriate, while Qualitative variable were summarised using frequencies and percentages. Data presentations were in form oftables, charts, and graphs. Client satisfaction of services was scored using a Likert scale from 1 to 5 where 5 indicated maximum satisfaction with services (Excellent) and 1 represented poor satisfaction; and the scores were graded using a system adapted from a past study.[81]Based on this system, out of a maximumscoreof 70 points, clients that scored 28 to 70 were graded as “satisfied” with the services obtained whereas those that scored 1 to 28 were adjudged as being “Not satisfied” with the services. In the same vein, respondents that scored 3 = good to 5 = excellent in any of the questions that elicited the

satisfaction were considered to be "satisfied" while those that scored 1 = poor and 2 = fair were considered "Not satisfied".

Data obtained from the qualitative interviews were transcribed and triangulated along main thematic areas using ZY – Table.

A ZY – Table is a simple table constructed with 2 colunm i.e response and Tally colunm which summarises all the interviews and analysed it along thematics areas e.g

RESPONSE	TALLY
1.............................	111
2..................................	11
3.................................	1111

ZY - Table

3.8 Ethical Consideration

The Ethical approval for the study was obtained from the ethical committee of Aminu Kano Teaching Hospital. The permission to conduct the study was also obtained from ministry of health and health service management board of Yobe state.

All respondents recruited in the study also sign or thumb print an inform consent form, after informing them that confidentiality would be ensured according to the provisions of Helsinky declaration on human subject research.

3.9 Limitations

Lack of access to some key stakeholders due to their tight schedule.

Because the purposive sampling was used in the study, the researcher cannot say with confidence the sample will be representative of the population.

CHAPTER FOUR

RESULT

A total of 229 questionaires were administered to the internally displaced persons (IDPs) , and 108 were administered to health workers across the IDP Camps and the health facilities examined. Two hundred and twenty three (223) and 104 questionaires were however returned completed from the IDPs and HCWs giving response rates of 97.4% and 96.3% respectively.

A sequencial mixed method of data collection were used, the qualitative data was first collected and the result was used to inform questions that were asked in the quantitative aspect of the data collection. The advantages of this methods is that information obtained on the feelings, opions and views of respondents enable the the researcher to properly understand the concept and ensure that the quantitative aspect would be enrich.

The internally displaced persons and the health workers were interviewed using pre – tested interviewer questionaire adapted from previous studies to collect information on the quantitative aspect of the dissertation while key stakeholders were interviewed using interview guide adapted from previous study to collect data on the qualitative aspect of the study. Using interview guide for the stakerholders will allow the researcher to get detailed information that will enreached the dissertation.

4.1. Socio-demographic characteristics of respondents

4.1.1. Socio-demographic characteristics of Internally Displaced Persons (IDPs)

Table 1: Socio-demographic characteristics of IDPs

Variable		Frequency (n=223)	Percent (%)
Age groups (Years)			
10-20		49	22.0
21-30		95	42.9
31-40		58	26.0
41-50		19	8.5
51-60		2	0.9
X ± SD	28.9 ± 8.9		
Sex			
Male		77	34.5
Female		146	65.5
Religion			
Islam		140	62.8
Christain		83	37.2
Ethnicity			
Kanuri		81	36.3
Ngizim		42	18.8
Karekare		36	16.1
Bade		25	11.2
Babur		39	17.5
Education			
No Education		36	16.1
Quranic Only		38	17.0
Primary		63	28.3
Secondary		77	34.5
Tertiary		9	4.0
Marital Status			
Married		124	55.6
Single		37	16.6
Divorced		22	9.9
Widowed		40	17.9
Area of settlement			
Home(IDP Leaving with relations)		135	60.5
IDP Camp		88	39.5

Table 1 above shows socio – demographic characteristics of the respondent. The mean age of the IDPs was 28.9 $\pm$ 8.9 years. Majority (90.9%) were between the age of 10 – 40 years upto 146 (65.5%) were females , 140 (62.8%) were muslims , 124 (55.6%) were currently married and 86 (38.5%) had atleast secondary school level of of education.

Table 2: Number of Children of the IDPs

Variables	**Frequency (n=223)**	**Percent(%)**
IDPs With no Children	37	16.6
IDPs With 1 – 4 Children	123	55.2
IDPs With 5 – 8 children	49	22.0
IDPs With 9- 12 children	14	6.3
X $\pm$ SD	24.2 $\pm$ 6.1	
Living children		
1 -5	152	81.7
6-10	34	18.3
X $\pm$ SD		
Dead children		
1 – 3	51	86.4
4 -6	8	13.6
X $\pm$ SD		

Table 2 above showed number of children of the respondent in which about 37(16.6%) were single with no children while 55.2% has children between 1 – 4 ,and only 6.3% of the respondent has children between 9 – 12, 81.7% of the respondent has children between 1- 5 alive and 86.4% of the respondent has children between 1 – 3 that were not alive.

4.1.2. Socio-demographic characteristics of health care workers

Table 3: Socio-demographic characteristics of HCWs

Variable	Frequency (n=223)	Percent(%)
Age groups (Years)		
20-30	65	62.5
31-40	34	32.7
41-50	1	0.9
51-60	4	3.9
X $\pm$ SD	30.3 $\pm$7.1	
Sex		
Male	56	53.8
Female	48	46.2
Religion		
Islam	75	72.1
Christian	29	27.9
Ethnicity		
Hausa / Fulani	41	39.4
Yoruba	8	7.7
Igbo	3	2.9
Others (Kanuri /karekare/Ngizim/Babur)	52	50.0
Education		
Secondary	9	8.7
Tertiary	95	91.2
Marital status		
Married	64	61.5
Single	25	24.0
Divorce	14	13.5
Widowed	1	1.0
Area of settlement		
Home (IDP leaving at home with relations)	98	94.2
IDP Camp	6	5.8

Table 3 above shows, socio – demographic characteristic of the health workers. The mean age of the HCWs was 30.3 $\pm$7.1 years . Majority 99 (95.2%) were between the age of 20 – 40 years. Upto 75 (72.1%) were Muslims , 48 (46.2%) were females , 64 (61.5%) were currently married and 104 (99.9%) had atleast secondary school level of education.

4.2. Leadership and governance in health system under conflict situation

4.3. Funding for health in Yobe state under conflict situation

The indepth interviews (IDI) with stakeholders revealed that hitherto the insurgency in Yobe state, health priorities were determined together with stakeholders in planning workshops conducted yearly in the state. The stakeholders for the workshop includes heads of units from health and health related ministries which include ministry of health (hospital management board (HMB), Primary health care board (PHC), Ministry of Agriculture, Budget and Economic Planning, Ministry of Local Government and Chieftaincy Affairs, Traditional Medicine Board etc. The decision in these workshops were guided by policy documents including : Yobe state socio – economic reform agenda 3 (YOSERA 3) , State strategic health development plan (SSHDP) 2010 – 2015 , Medium Term Sector Strategy (MTSS) 2013 – 2015 and National Demographic and Health Survey (NDHS), they also used other policy documents / statements from the state government , federal policies, data from health management information system (HMIS) etc.

Since the onset of the insurgency in Yobe, the government through the Ministry of Health(MOH) in collaboration with State Emergency Management Agency (SEMA) respond only to the emergency needs of the people by providing them with basic amenities in temporary settlements referred to as IDP Camps. There has not been any new government policy on the health care of the IDPs. Health care workers in areas affected by the insurgency were given the leverage to stay off duty in times of serious security threats. There is also no laid down process for allocating funds or budgeting for the health emergencies. Most of the funds and logistic

support for the camps are provided by development partners who also provide staff that work on the camps.

4.3. Funding for health in Yobe state under conflict situation

4.3.1 Health financing

During indepth interview with stakeholders, majority of the policy makers said that funding for health has deteriorated because of the insecurity in the state.The reason is that the resources that are spent on security in the state is very colossal. Because of the conflict situation, lack of enough human resources and deteriorating health condition on ground, about two years three months ago at the peak of the insurgencythe Governor declared state of emergency in the health sector, so as to respond appropriately to all the challenges health wise. And this has resulted to an increase in the budgetry allocation from 50% to about 75%in the health sector.In the past two years the budgetry allocation to the ministry of health has relatively increased compared to the previous years as mention early due to the priority given to the health sector,and this has also improved the releases made to the ministry of health to pursue health related issues. The state government set up a committee that will supervise how this fund release by the government will be used/ manage which resulted in to fair coordination and accountability.

4.3.2: Availability of basic amenities on IDP Camps

Table 4: Perspectives of Health workers on availability of basic amenities in IDP camp HF

Parameter	**Frequency (n =104)**	**Percent(%)**
Provision of proper solid waste disposal	85	81.7
Provision of separate rooms for males and females	73	70.2
Provision of electricity supply	56	53.8
Provision of adequete security	76	73.1
Provision of adequete toilet facilities	81	77.9
Provision of regular supply of potable water	69	66.4

Table 4 highlights the perspectives of the health workers about availability of basic amenities in IDP Camps in Yobe State. The majority of the respondents testified that basic amenities including potable water supply, toilet, security and shelter were available for the IDPs.

Table 5: Perspectives of the HCW in IDP HF on availability of basic amenities in camps

Parameter	Frequency (n =228)	Percent(%)
Adequate provivisions for male and female rooms	201	88.2
Separate cubicles/ partitions for family members	187	82.0
Adequete toilet faciliies for male and females on camps	201	88.2
Method of solid wastes disposal in camps		
- Open dumping	192	84.2
- Burying	189	82.9
- Burning	173	75.9
Regular supply of potable water	154	67.5
Sources of potable water on camp		
- Pipe borne	165	72.4
- Sanitary well	137	60.1
- Unsanitary well	89	39.0
- Tank	78	34.2
Regular supply of food on camp	136	59.7
Sources of food on camps		
- Self	176	77.2
- Government	156	68.4
- Donors	191	83.8

The perspectives of the HCW in IDPs on the availability of basic amenities in the camps is summarised in table 5 above. The interview with the majority of the displaced persons revealed that there were adequate provisions for shelter for both males and females (88.2%) and there were provisions for separate cubicles for family members (82.0%), and that toilet facilities for males and females were adequate (88.2%). More than half of the IDPs (67.5%) affirmed having regular supply of potable water on the camp, and 59.7% said that food supply was also regular on the camp.

4.4. Health Service delivery in Yobe state in conflict situation

During the indepth interviews (IDIs) with the policy makers, it was revealed that service delivery in the State has changed in respond to the security challenges inthe state. Most facility based services are completely distabilized, and people in the affected communities have been displaced to different emergency camps. Thus, health services for such groups are delivered on camps. The human resources for health were also affected by the insurgency. Health workers who are affected by the insurgents were redeployed to alternative places where they can now be effectively used. And then, the type of services rendered, depend on the situation, they have mobile clinics, they have camps, and then they have fixed out post that have been on ground and will make sure that services are able to reach those who need them at any time.

4.4.1 Availability of health services in IDP Camps

This study elicited availability of health services on camps from the perspectives of both the IDPs and the health workers working on the camps.

Table 6: Health workers perspective about health services on IDP camps

Parameter	Frequency (n = 104)	Percent(%)
Availability of 24hrs health services	79	76.0
Health sefvices available on camp		
- Ante natal clinic (ANC)	86	82.7
- Delivery services	75	72.1
- Immunisation services	72	69.2
- Minor surgical procedure	67	64.2
- Health education services	85	81.7
- General consultation services	96	92.3
Adequete staffing in health facility on camp	56	53.8
Adequete equipment in health facility on camp	67	64.4
Good renumeration for staff in health facility serving camp	69	66.4
Safety precautions in health facility on camp	84	80.8

Table 6 above depicts Health workers perspective about availability of health service on IDP camps.More than three – quarters of the health workers said that health services were available 24hours on the camps (76.0%). Services mentioned by the majority included general consultation services (92.3%), health education (81.7%), ANC(82.7%) and delivery services (72.1%).

However , about half of the workers affirmed that there were adequate health staff on the camp(53.8%) and 64.4% also mentioned that equipment for delivery of health services were adequate on the camps. Other perspectives of the health workers on health services delivery on the camps are as summarized in Table 6.

Table 7: IDPs perspectives about health services available on IDP camps

Parameter	**Frequency (n =228)**	**Percent(%)**
Routine immunisation	186	81.6
Nutrition service	167	73.2
IMCI services for children	156	68.4
ANC services	185	81.1
Delivery services	176	77.2
Post natal/ family planning services	170	74.6
Youth friendly services(HCT, Condom etc)	110	48.2
GOPD services	222	97.4
Health education sessions on camps	212	93.0

Table 7 above shows the perspectives of the IDPs on health services availability in the camps. Health education services (93.0%) and GOPD servives (97.4%) were the most common services mentioned. On the other hand youth friendly services were the least mentioned (48.2%).

4.4.2: Clients Satisfaction with services obtained from IDP Camps

Table 8:Result of Assessment of level of satisfaction with services in IDP Camps

ACCESS:	Excellent 5 n(%)	V/good 4 n(%)	Good 3 n(%)	Fair 2 n(%)	Poor 1 n(%)
1. Ease of getting care:	21(9.4)	153(68.4)	44(19.7)	5(2.2)	0
2. Hours clinic is opened	56(25.1)	108(48.4)	53(23.8)	6(2.7)	0
3. Convenience of clinic's location	38(17.0)	119(53.4)	62(27.8)	4(1.8)	0
4. Ease of reaching your doctor in case of emergency	1(0.4)	113(50.7)	103(46.2)	6(2.7)	0
5. Ease of reaching your nurses / midwife in case of emergency.	0	96(43.0)	122(54.7)	5(2.2)	0
6. Ease of reaching the laboratory staff by phone	0	76(34.1)	136(61.0)	11(4.9)	0
Waiting time:					
7. Time spent waiting for consultation	0	68(30.5)	150(67.3)	5(2.2)	0
8. Time spent with doctor	1(0.4)	78(35.0)	133(59.6)	11(4.9)	0
9. Time spent waiting for tests to be done	0	63(28.3)	150(67.3)	10(4.5)	0
10. Time spent waiting for testresults.	0	75(33.6)	139(62.3)	9(4.0)	0
11. Level of satisfaction with overall time spent in the hospital	2(0.9)	114(51.1)	96(43.0)	11(4.9)	0
HEALTH WORKERS					
12. How does health workers in this health facility attend to you?	0	101(45.3)	117(52.5)	5(2.2)	0
13. How do you assess the treatment given to you by the health workers in this health facility?	0	88(39.5)	124(55.6)	11(4.9)	0
14. How do you assess the adequacy of health workers in this health facility	0	92(41.3)	122(54.7)	9(4.0)	0

TABLE 8 above shows likert scale result in percentages and frequencies for each variable, assessing level of satisfaction with services in IDP Camp. The scores ranges from 1 to 5(5= excellent, 4= Very good, 3= Good, 2= Fair and 1= Poor).

Table 9: Parameters used for assessing clients satisfaction with health services

ASPECT OF CARE	FREQUENCY n = 223	PERCENT (%)
ACCESS TO CARE		
Ease of getting care	218	97.8
Hours clinic is open	217	93.3
Convenience of clinics location	219	98.2
Ease of reaching doctor in case of emergency	217	97.3
Ease of reaching your nurses in case of emergency	218	97.8
Ease of reaching the laboratory staff by phone	218	97.8
WAITING TIME		
Time spend waiting for consultation	218	97.8
Time spent with doctor	218	97.8
Time spent waiting for tests to be done	213	95.5
Time spend waiting for test results	214	96.0
Level of satisfaction with overall time spent in the hospital	212	95.1
HEALTH WORKERS ATTITUDES		
How does health workers in this health facility attend to you?	218	97.8
Assessment of treatment given to you by the Health workers in the health facility	212	95.1
Assessing the adequacy of health workers in this health facility	214	96.0

Table 9summarizes parameters used to assess clients satisfaction for the health services they obtained from the IDP Camps. Most of the IDPs were satisfied with access to health care in the camp; with waiting time to be attended at the facilities and with the attitude of the health workers working on the camps.

Regarding Access to care 218(97.8%) of respondents reported ease of getting care as compared to 217(93.3%) who reported the hours that clinic was open, while in the case of Waiting Time, 218(97.8%) of the respondents reported Time spend waiting for consultation as compared to 212(95.1%) who reported the level of satisfaction with overall time spent in the hospital.

Regarding Health workers Attitude, 218(218%) of the respondents reported how health workers in the health facilities attend to you as compared to 212(95.1%) who reported the Assessment of health workers adequacy in the health facility.

Table10: Grades of IDPs Satisfaction with health services obtained from camps

Satisfaction grades	Frequency n = 223	Percent(%)
Satisfied	223	100.0
Not Satisfied	_	_
Total	223	100.0

Overall, all the clients interviewed(100%) were satisfied with services obtained from IDP Camps as shown in table 10.

4.5. Role of public , Private and NGO sectors in service delivery

Most of the indepth interviews (IDIs) held with stakeholders revealed that development partners contributed immensely to provision of health care on the IDP Camps. The UNICEF,WHO , Red Crossand other UN agencies provide both technical and financial support to attend to health emergencies and disasters arising from the security challenges in the state. These agencies have special projects to carter for the displaced persons, affected communities by providing health equipment, and capacity buildings for staff on emergency management, management of rape victims, anti social support among others. Government agencies like the State emergency management agency(SEMA) and the National emergency management agency(NEMA)work closely with the NGOs in providing technical support to the state.

CHAPTER FIVE

DISCUSSION

5.0 Discussion

In the various IDPs camps, there were 223 respondents interviewed, with mean age and standard deviation of 28.9 $\pm$8.9. However, majority of respondents were between the age of 21-30 (42.9%). This is similar to a study conducted in Iraq with mean age and standard deviation of 28.4 $\pm$.8.6,the similarities may be as a result of both countries were located on the same continent (Africa).[82]Majority of the respondant were female 146(65.5%) compared to the male which is 77(34.5%).This is similar to a study conducted in Iraq with male to female ratio of 148 (68.5%) to 75 (31.5%) respectively, the similarities may be due to the frequent attack as a result of conflict situation targeting the males in the community.[82]The majority of the camp population were predominantly Muslim 140(62.8%), compared to the Christians population 83(37.2%), this is similar to study conducted in Syria with Muslim to Christian ratio of 135 (58.8%) to 86 (41.2%) respectively, the similarities may be due to the fact that the community is predominantly dominated by Muslim.[82]

The majority of population affected by these conflict situation were predominantly those with level of education ranging from secondary education 77(34.5%) followed by primary education 63(28.3%) and those without education 36(16.1%),these is similar to a study conducted in Afganistan with majority of the population affected were those with level of education ranging from secondary and those without education , the similarity may be as a result of most of the

population were predominantly from rural communities with low socio-economic status and lack of access to education.[83] The majority of the population that were affected were married women124(55.6%),followed by the widowed 40(17.9%) and divorcee 22(9.9%),this is similar to a study conducted in Iraq where the majority of the population affected by the conflict were married 59% followed by widowed 36.1%,the similarity may be due to the fact that the majority of the population predominantly affected were from rural area and low socio-economic background and problem of early marriage in rural area,furthermore,the conflict situation mostly are targeting males and hence more widows in the population.Most of the population of the IDPs were found in the communities leaving with relations 135 (60.5%) compared to those residing in the IDPs camp 88 (39.5%), this is different from the finding obtained from a study conducted in Syria with population of those residing in the IDP camp and community were 420 (65.5%) and 215 (48.2%) respectively,the differences may be as aresult of in the case of Yobe state most of the population residing in the capital of the state were derived from nearby villages and most of the insurgency affect those villages and hence they were accommodated by there relatives residing in the community rather than going to the camp, in addition , also probably there were no enough IDP camps in Yobe compared to Syria.[82]

Most of the population residing in the IDPs camp has number of children ranging from 1 to 4 (55.2%) with very few IDP camps members having the highest number of children 9 -12(6.3%) and the majority of the population has children between 1 – 5(81.7%) that are alive and those that lost 1 – 3 children has the highest number in the camp,this is similar to the finding obtained in a study conducted in Sierra leone in which the majority of the population residing in the IDP camp has children between 2 –4(61.2%),the similarity may be as a result of those affected by the

insurgency were younger (within the reproductive age group) with few number of children while those with the highest number of children (9 -12) were found among older age group with lowest number in the IDP camps.[84]

In the various IDP camps and the community in general we have health facilities that is being managed by the health personels from the state government with some re-inforcement from NGOs and private organisation. There were 104 respondents interviewed, with mean age and standard deviation of 30.3 ±7.1. However, majority of respondents were between the age of 20-30 (62.5%). This is different from a study conducted in Syria with mean age and standard deviation of 33.4 ±.9.6,the difference may be as a result of both countries were located on the different continent (middle east) with different socio – economic status and cultural background[82] . Majority of the respondant were males 56(53.8%) compared to the female which is 48(46.2%).This is similar to a study conducted in Congo with male to female ratio of 58 to 31 respectively, the similarities may be due to the fact that more males than females especially in this part of the country go to school,while the females married early rather than going to school[85].The majority of the Health workers were predominantly Muslim 75(72.1%),compared to the christain population 29(27.9%),this is similar to study conducted in Palestine with male to female ratio of 64 to 32 respectively, the similarities may be due to the fact that the community is predominantly dominated by Muslim.In the community and the camp Kanuri / Karekare / Ngizim 52 (50%) tribe were more in number followed by Hausa / Fulani 41(39.45%) this is because the former are the dominant languages in the state(Yobe).

The health workers predominantly have tertiary education 95 (91.1%), followed by secondary school education 9(8.7%),this may be due to the nature of the health personel in which predominantly the workers are nurses, doctors ,CHOs and student from school of health technology across the state. The majority of the health workers in the state are married64(61.5%) with some percentage which are not married 25(24%),this may be due to the cultural and religious background(Early marriage) in the state. Most of the health workers are residing outside the camp 98(94.2%) while very few reside in the camp 6(5.8%), this may be due to lack of accomodation for the health workers in the camp especially for the doctors.

During the indepth interviews (IDI) with stakeholders on leadership and Governance the respondent revealed that, health priorities were determined together with stakeholders in planning workshops conducted yearly in the state which is guided by policy documents including : Yobe state socio – economic reform agenda 3 (YOSERA 3), State strategic health development plan (SSHDP) 2010 – 2015 , Medium Term Sector Strategy (MTSS) 2013 – 2015 and National Demographic and Health Survey (NDHS), they also used other policy documents / statements from the state government , federal policies, data from Health management information system (HMIS) . This is similar to a study conducted in Afganistan on leadership and governance in which decision is taking after series of workshops guided by some policy document, and the similarity may be due to the same condition in which the two countries were subjected to (Conflict situation which needs effective planning before making decision)[86].

Two third of the respondent revealed that funding for health has deteriorated as aresult of the conflict situation in the state.This is due to the fact that the resources that are spent on security in the state is very colossal. The reason being that the conflict situation has result in to inadequate human resources and deteriorating health condition on ground, then the Governor declared state of emergency in the health sector, so as to respond appropriately to all the challenges health wise, which has resulted to an increase in the budgetry allocation to the health sector and hence priority given to the healthand this has also improved the releases made to the ministry of health to pursue health related issues . This study is similar to a study conducted in Pakistan where the Government base on annual committee report increases budgetry allocation to health sector as a result of conflict situation affecting the health of the population.[87]

Three quater of the displaced persons (IDPs) revealed that there were adequete provisions for shelter for both males and females , provisions for separate cubicles for family members, toilet facilities for males and females , regular supply of potable water in the camp and regular supply in the camp.

With more efford from NGOs and private organisation , states and federal Government such as National Emergency Management Agency (NEMA),the IDP camp members received good health care services and almost all the needed materials were provided such as separate rooms for male and females,partition for family members,adequate toilet facilities , regular supply of water with sources from pipe borne and sanitary well and there is wateravailable all the time,about the same percentge of the population(39.5%) agreed that there is regular supply of food to the camp twice daily usually by the Government ,NGOs with some effort from the

communities and also from the IDPs themself, unfortunately no regular supply of electricity to the camp which is a major problem affecting the whole Nation. NGOs, Private organisation and Government provides beds, matresses,blanket and security to the camp with some little effort from the IDPs and the community,with the help of the Government and above mentioned organisation there is adequate toilet facility and good hygien was maintain in the camp with appropriate method of solid waste disposal which include burying and burning the solid waste and sometimes they use open dumping as a method of solid waste disposal.[88]

The Government also in collaboration with NGOs provide basic aminities and health services which include Routine immunisation,Nutrition services, IMCI, delivery services,post natal care/ family planning, Ante natal care, GOPD services and Health education services,while only Youth friendly services that is occationally being provided. Based on the above findings the Government in collaboration with the private organisation assisted in the provision of basic aminities and health care services to the IDPs in the Camps and the more objective method of assessing this is by going to the camp with your check list to see for youself. The is similar to the finding in a research conducted in Iraq were about 90% of there basic amenities/ Health facilities were provided by NGOs and Government.[88]

Tree quater of the IDPs populations after the interviews were found to be satisfied with access to health care on the camp; with waiting time to be attended at the facilities and with the attitude of the health workers working on the camps, and almost all the respondent were satisfied with services obtained from IDP Camps.This is similar to a study conducted in Afganistan where

about 90% of the respondentwere satisfied with the services being provide by the Government and the NGOs,this may be due to commitment of the Government to provide necessary support to the Health facilities.[89]

Ninety percent of the respondent revealed that development partners play a major role in the provision of health care in the IDP Camps. The agencies (UNICEF,WHO, Red Cross and other UN agencies) provide both technical and financial support to attend to health emergencies and disasters arising from the security challenges in the state.These agencies have special projects to carter for the displaced persons, affected communities by providing health equipment, and capacity buildings for staff on emergency management, management of rape victims, anti social support among others. This is similar to study conducted in Syria where Government, NGOs and other agencies provide about 80% of basic aminities and health care to the population.[89]

CHAPTER 6

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The studyhas found outthat the majority of respondents were between the age of 21-30 (42.9%) with the mean age of the IDPs and HCW to be 28.9 $\pm$ 8.9 and 30.3 $\pm$ 7.3 years respectively. There were IDP camps managed by government with support from local and international NGOs, the services availableare adequate. Similarly most of the IDPs were 100% satisfied with services rendered by the HCWs such as access to health care; waiting time to be attended at the facilities and with the attitude of the health workers working in the camps.

Althoughthe insurgency has lasted for over six years the priority settings in the health care system within the state has significantly changed in line with the prevailing health problems cause by the insurgency. Because ofthe conflict situation, lack of enough human resourcesand deteriorating health condition on ground, the Governor declared state of emergency in the health sector, so as to respond appropriately to all the challenges health wise, And this has resulted to an increase in the budgetry allocation to the health sector.

6.2 Recommendations

The findings from the study have made me to offer the following recommendations as a way forward.

6.2.1 Governance and Leadership

1. There is need to established a strong leadership structure in the IDPs camp

2. There is need to improve the facilities (water supply, sanitation and accomodation in the IDP camps) by the Government.

6.2.2 Funding

1. There is need to get more support in terms of funding from both state and Federal government in order to improve quality of services and social amenities in the IDP camps.

6.2.3 Service Delivery

1. There is need for the Government to strengthen medical and social rehabilitative services

2. The community should increase the support to the victims both within and outside the IDP camps through intergration.

3. The Government Should assist in the form of sponsorship for education of orphans and other children affected by the insurgency.

6.2.4 Partnership Coordination

1. The partners should be conducting researchs on the medico social needs of the IDPs and dessiminate it to the relevant stakeholders for planning and implementation of health and social intervention.

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APPENDIX 1: HEALTH WORKERS QUESTIONAIRE

S/NO......................... **TYPE OF Health Facility...........**

DEPARTMENT OF COMMUNITY MEDICINE, AMINU KANO TEACHING HOSPITAL (AKTH), KANO

Dear respondent,

My name is Dr Jibril Adamu Damazai. Iam MPH Student from Bayero University Kano. Iam under taking a survey as part of the requirement for the fulfilment of the award for the MSc program. This interviewer-administered questionnaire is to elicit information about Priority Setting in conflict situation: A Case study of yobe state Health System. Any information obtained shall be treated with strict confidentiality.

Section A: Socio-demographic data:

1. How old are you (from last Birth day)?..years..
2. Indicate the respondents Sex.Male ☐ Female ☐
3. What is your Religion? a ☐ ☐ ianity

   c. Others specify ………………..

4. To Which ethnic group do you belong to?: a. Hausa/ ☐ b. Y ☐

   c. Igbo ☐ d. others specify ……………………………

5. What is your highest educational qualification?

   a. Primary ☐ . Secondary ☐

   c. Tertiary ☐ d. others specify ……………………………

6. What is your Marital Status: a. Married ☐ b. Single ☐ c.

   C. Divorced ☐ d. Widowed ☐ e. Seperated ☐

   e. others Specify ………………………………………

7. Where do you currently lives? a. Home ☐ b. ☐

If Home

8.How long does it take you to get to the hospital from your home?(Mins).......................

9.How much do you spend on transportation to the hospital from your home?(N)..............

10.Is this amount affordable to you? a. Yes ☐ b. No ☐

11. Where is your health centre located?

a. IDP Camp b. Con

12. If in the Camp, do you have proper solid waste disposal?

a . Yes

13 .Do you have Separate rooms for males and females

a. Yes c. No

14. . Do you have regular supply of Electricity . No

15. Do you have Adequate security in the IDP Camp? a. Yes b. No

16. How do you maintain the quality of the water used by the IDPs for drinking and / or cooking?..
....

17. Do you have adequate Toilet facilities on the camp? b. No

18. How is hygiene maintained and contamination of food and water by faecal matter prevented at the IDP camp ?

....

....
......

19. . Are the following services available in the clinic / health facility on the camp?

a. Routine immunisation

b.. Nutrition servvices o

c. IMCI services(Diarrhoea,ARTI and Malaria) Yes No

d. ANC No

e. Delivery services Yes No

f. Post natal care/ family planning s No

g. Youth friendly services(HCT, condoms etc) yes No

h. GOPD Yes No

i. Health Educ. Sessions on camps es No

20. What is the total population of inhabitants of this camp?...............................

21. Do you run 24hrs services? a. Yes b. No

22. What is the level of patronage of the Health facility?

a. Excellent b. V/Good ood d. Fai e.

Poor

23. Do you have adequate staff in your Health facility?

Yes

24. Do you have Adequate equipment for delivery of the services outlined in Q19 above

Yes No

25. How available are consumables available for delivery of services in Q19 above?

a. Always b. Mos c. Sometimes

25. Do you have Safety precautions practices? Yes No

26. Do Health workers working on the camp have separate arrengement for

a. Rest room No

b. Toilet facilities No

c. Food and water supply Yes No

d. Allowance(special) No

e. Transportation to and from home o

f. Security for family members while worker is at wo s No

APPENDIX 2: EXIT INTERVIEW QUESTIONAIRE

S/NO:................... **TYPE OF Health Facility:.............**

DEPARTMENT OF COMMUNITY MEDICINE, AMINU KANO TEACHING HOSPITAL (AKTH), KANO

Dear respondent,

My name is Dr Jibril Adamu Damazai. Iam MPH Student from Bayero University Kano. Iam under taking a survey as part of the requirement for the fulfiment of the award for the MSc program. This interviewer-administered questionnaire is to elicit information about Priority Setting in conflict situation: A Case study of yobe state Health System. Any information obtained shall be treated with strict confidentiality.

Section A: Socio-demographic data:

7. How old are you (from last Birth day)?..years..
8. Indicate your Sex. a. Male b. Female
9. What is your Religion? a. Islam b. Christianity c. Others specify ………..
10. To Which ethnic group do you belong to?: a. Kanuri/Manga b. Ngizim c. Karekare d .Bade e. Babur/Bura f. others specify ....
   a. What is your highest educational qualification? a. No education b .Quranic only c. Primary d.. Secondary.e. Tertiary

   D. What is your Marital Status: a. Married b. single c.Divorced d. Widowed e. Seperated
11. Number of children.......................... Living................ Dead........................

SECTION B: Availability of emergency Health Services

Where do you currently live? A. Home b. IDP Camp

If Living in the IDP Camp

9. Are there separate rooms for Males and Females? a. Yes b. No

10. Are there partitions for family members? a. Yes b. No

11.Are there adequate toilet facilities in the camp? a. Yes b. No

12. How do you dispose off solid waste in the camp?

a. Open dumping b. Burrying c. Bunning d. Temporary storage in plastic

e. others specify ....

12. Do you have regular supply of portable water ? a No

13. Sources of water supply

a. Pipe borne b. Sanitary well c. Unsanitary well d. Tank(supply by tanker)

14. How regular is the supply? a. All the time b. Occasionally

15. Is there a regular supply of food on the IDP camp? a. Yes b. No

16. If yes, what is the source of the food on camp.

a. Self b. Government c. Donors

17. How many times in a day? a. Once b. Twice c. Three times

18. Do you have regular supply of Electriccity? a. Yes b. No

19. Are there school for children on the camp? a. Yes b. No.

20. Are the following available to the majority of the IDPs on the camp?

a. Bed /Matress Yes b. No

b. Blanket Yes b. No

c. Security Yes b. No

21. Where is the Health facility serving this camp located? a. Within b. Outside

22. How far is the health center from the IDP camp(in km).............................

23. How long does it take to reach the health center by foot (mins)................................

24. If living outside IDP, how close is your house to the nearest functional health facility(in km)................

25. How long does it take to reach the health facility by foot (mins)........................

26. Are the following services available in the clinic / health facility that you attend?

a. Routine immunisation yes No

b.. Nutrition servvices Yes No

c. IMCI services(Diarrhoea,ARTI and Malaria) Yes No

d. ANC Yes No

e. Delivery services Yes No

f. Post natal care/ family planning Yes No

g. Youth friendly services(HCT, condoms etc) Yes No

h. GOPD Yes No

i. Health Educ. Sessions on camps Yes No

SECTION C: Assessment of level of satisfaction.

Please circle how you assess the service you or your child received in the following area **ACCESS:**	**Excellent** **5**	**V/good** **4**	**Good** **3**	**Fair** **2**	**Poor** **1**
3. Ease of getting care:	5	4	3	2	1
4. Hours clinic is opened	5	4	3	2	1
5. Convenience of clinic's location	5	4	3	2	1
6. Ease of reaching your doctor in case of emergency	5	4	3	2	1
7. Ease of reaching your nurses / midwife in case of emergency.	5	4	3	2	1
8. Ease of reaching the laboratory staff by phone	5	4	3	2	1
Waiting time:					
9. Time spent waiting for consultation	5	4	3	2	1
10. Time spent with doctor	5	4	3	2	1
11. Time spent waiting for tests to be done	5	4	3	2	1
12. Time spent waiting for test results.	5	4	3	2	1
13. Level of satisfaction with overall time spent in the hospital	5	4	3	2	1

HEALTH WORKERS:	5	4	3	2	1
14. How does health workers in this health facility attend to you?	5	4	3	2	1
15. How do you assess the treatment given to you by the health workers in this health facility?	5	4	3	2	1

16. How do you assess the adequacy of health workers in this health facility	5	4	3	2	1

APPENDIX 3CONSENT FORM

I am Dr Jibril Adamu Damazai an MPH student in the department of public health , Bayero University Kano, am conducting a study on Priority Setting in Conflict situation: a case study of Yobe state Health system in Yobe state, the study will assist me in determining how the leadership and Governance for health and Funding for Health changed in response to the health system demand and also how the service delivery structure change in response to the needs of the population. As a participant, i would request that you repond to the research questionaire which may take about 30 minutes. If you agree to participate, kindly sign in the space provided below. Particition is entirely voluntary. Refusal to participate will not affect you in any manner.

Thank you.

Name of participant:.. Sign / Thumbprint:...............................

Date:..

Name of Researcher :...Signature : ....

Date : ....

APPENDIX 4: INDEPTH INTERVIEW GUIDE

1. What is your role in terms of setting priorities and allocating resources for Health in Yobe state?
2. What sources of information were you using in determining short and long-term priorities in your state?
3. What sources of information are currently being used in determining short and long-term priorities in your state under this emergency situation?
4. What types of information (or data or evidence) would you most want to use in setting priorities and allocatingresources?
5. How has the leadership and Governance for the Health system responded to the conflict situation in Yobe state? (Policies,Accountability,Coordination)

6. How has the funding for Health changed in response to the conflict situation in Yobe state?
7. How has the service delivery change in response to the conflict situation in Yobe state ? (Structure of service delivery,Availability of service,Type of service,)
8. What can you say about the role of partners for health in the conflict situation in Yobe state?
9. Once priorities are defined, how are decisions made to apportion the resources across the state (or various services within your state)?
10. In your opinion, does the current process of setting priorities and allocating resources work well?
11. What are the strengths , weaknesses and opportunities of the current process?
12. In your opinion, how would the current process of setting priorities and allocating resources be improved?
13. How has the public been involved in priority setting/resource allocation processes in the past?
14. How is the public being involved in setting priority/allocation of resources for health in the current conflict situation?
15. Ideally, how would you want the public to be involved in the priority setting/resource allocation process?
16. What information is important from the public?

APPENDIX 5: LIST OF KEY STAKEHOLDERS

MINISTRY OF HEALTH	NAME	POSITION
	Dr M Kawuwa	**Hon Commissioner**
	Dr Usman Mohammed	**Director Medical Services**
	Dr Lawan Gana	**Director Public Health**
		Director finance and supply
		Director personnel mgt
		Director planning, Rearch and Statistics
		Epidemiologist-State
		Control officers for TB and Leprsy,HIV/AIDS, Rold Back Malaria.
State Primary Health Care Board(SPHCB)		
	Dr Hauwa L Goni	Director Primary Health Care
		State immunisation officer
		Maternal and Child Health

		Programme officer
		Health education officer
		State Monitoring and Evaluation officer
Ministryof Local Government andChieftaincy Affairs (MLGCA)		
		Permanant Secretary
		Director Finance and Supply
		Director Budget and planning
		Director Joint Account

AMINU KANO TEACHING HOSPITAL

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NHREC/21/08/2008/AKTH/EC/1461

AKTH/MAC/SUB/12A/P-3/VI/1561 **3rd August, 2015**

Dr. Jibril Adamu Damazai
Department of Medicine
BUK, Kano.

Ufs:

The Head of Department
Medicine
BUK, Kano.

ETHICS APPROVAL

Further to your application in respect of your research proposal titled "Priority Setting in Conflict Situation: A case Study of Yobe State Health System", the Committee reviewed your proposal and noted same as a Prospective/Questionnaire based Study.

In view of the above, Ethics approval is hereby granted to conduct the research.

However, the approval is subject to periodic reporting of the progress of the study and its completion to the Research Ethics Committee.

Regards

Abubakar S. Mahmud
Secretary, Research Ethics Committee
For: Chairman