

Effects of civil war on maternal and child health care in sub-Saharan Africa

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Abstract

The aim of this thesis is to investigate an issue of great concern in developing countries: the impacts of civil conflict on access to and use of health maternal and child health care services, in sub-Saharan Africa. In many ways the thesis is a response to the landmark United Nations Security Council Resolution 1325 and its call for greater knowledge about the impact of conflict on women and girls (UN SC 2000). In this thesis I will regard improvements in health as development in itself. This is in contrast to actors who see health improvements as a means to achieving greater (economic) development. I further argue that the different approaches to improving maternal and child health that are discussed by actors in the public health field and others are discussions of development strategies, although perhaps not conventionally defined as such.

The use of quantitative approaches comparing information across many countries was combined with more in-depth information from interviews in what is now South Sudan. Maternal and child health goals now figure prominently on the international development agenda, and are selected as Millennium Development Goals 5 and 4 respectively, but despite this focus there is still a very long way to go in order to secure adequate health care in the countries included in this thesis. Few of them will be able to reach the targets set by 2015.

Having access to new geo-coded information on occurrence of civil conflict made it possible to compare effects both on a national and sub-national level (i.e. across and within countries). In the first article it was found that civil war countries overall had lower use of maternal health care services, but that having battles within a shorter distance from the location where health data was collected was associated locally with *more* and not less use of the health care services. In the second article it was found that countries embroiled in civil war had a higher occurrence of children with fever but also a one percent higher rate of children vaccinated against measles. Investigation on a sub-national level indicated again against expectations that the proximity to battles was associated with less fever and a higher chance of being vaccinated against measles.

The results were thus different on the two levels of analysis. The conclusion I draw is that civil conflict has a wider, negative systemic effect on the health care services (and child fever) in the affected countries, but that locally the battles tend to take place in areas of more strategic interest, where health care services are at the same time more likely to be delivered by both national and international actors. The negative effects of the fighting are therefore 'covered up' in the statistical analyses.

The level of inequality in service access between different areas within the same country is evident in all the countries studied here. Even when the detrimental impacts of civil conflict affect the best served areas, the negative impact on health care does not show up in the statistical results because the difference compared to marginalized areas is still too large. These findings mean that local politicians and donors need to make a much greater effort to make maternal and child health care services available outside central areas in conflict-affected countries, and in article four I discuss the relationship between conflict, equality and equity in health. On a positive note the results also suggest that some efforts of particular concern for conflict-affected populations are working, as seen in the slightly higher likelihood of being vaccinated against measles.

The findings regarding the distribution of military battles and the link with health care services are partly supported by information from interviews with men and women in South Sudan as presented in the last two articles. This country has been ravaged by Africa's longest running civil conflict, and in many ways the second civil war amounted to 22 years of lost development opportunities for this newly established country. It starts out its existence with probably the world's highest estimated maternal mortality ratio (although the estimates are somewhat uncertain). The time window to find out how many women really died of maternity-related factors specifically because of the war has probably passed now. As far as the civil war contributed to a higher number of maternal deaths by increasing women's vulnerability and preventing access to life-saving maternal health care services, I call them *uncounted war deaths*.

Information from government-held Juba was compared to the situation in Magwe, which changed hands between several military factions. Juba was the central garrison town in the south during the war and was never taken by the SPLA, who otherwise controlled most of the surrounding countryside. While more military battles (narrowly defined) between the SPLA and the northern regime were reported around Juba than in Magwe, the inhabitants in Juba also received much more assistance, by both national and international actors. The most important attacks on Juba were however concentrated in time, whereas in Magwe the inhabitants were subject to more low-level but very destructive and disruptive warfare. The findings may therefore also be used to draw attention to the how we think about and measure warfare. There was a sharp inequality in access to assets and services between these locations that continued even after the signing of the Comprehensive Peace Agreement in 2005. I argue that this inequality in access to health care services is unfair, in other words it is a matter of inequity.

When I asked in the interviews about more specific barriers that prevented access to maternal health care, the informants revealed that payments that are asked for maternal health care services are one of the greatest obstacles to increasing use of this life-saving aid. One of the policy recommendations to come out of this project is therefore to try to avoid charging user fees for maternal health care services. Payments reinforce the pre-existing inequality between richer and poorer South Sudanese women, and prevent them from accessing help in a situation that can at times be life-threatening. From my research I draw the conclusion that civil conflicts may contribute to greater inequality of access to and use of maternal and child health care, in countries that already strive to achieve equality for their inhabitants in many important spheres of life. Developing more equitable maternal and child health care is acutely needed in conflict-affected countries.