Available online at www.sciencedirect.com
ScienceDirect
Health Policy 83 (2007) 84–93
HEALTH policy
www.elsevier.com/locate/healthpol

Reconstruction of health service systems in the post-conflict Northern Province in Sri Lanka

Mari Nagai [a,*], Sandirasegaram Abraham [b], Miyoko Okamoto [a], Etsuko Kita [c], Atsuko Aoyama [a]

[a] *Department of International Health, Nagoya University School of Medicine, Japan*
[b] *Deputy Provincial Director of Health Services, Trincomalee, Ministry of Health, Government of Sri Lanka, Sri Lanka*
[c] *The Japanese Red Cross Kyusyu International College of Nursing, Japan*

Abstract

Public health problems in armed conflicts have been well documented, however, effective national health policies and international assistance strategies in transition periods from conflict to peace have not been well established. After the long lasted conflicts in Sri Lanka, the Government and the rebel LTTE signed a cease-fire agreement in February 2002. As the peace negotiation has been disrupted since April 2003, a long-term prospect for peace is yet uncertain at present.

The objective of this research is to detect unmet needs in health services in Northern Province in Sri Lanka, and to recommend fair and effective health strategies for post-conflict reconstruction. First, we compared a 20-year trend of health services and health status between the post-conflict Northern Province and other areas not directly affected by conflict in Sri Lanka by analyzing data published by Sri Lankan government and other agencies. Then, we conducted open-ended self-administered questionnaires to health care providers and inhabitants in Northern Province, and key informant interviews in Northern Province and other areas.

The major health problems in Northern Province were high maternal mortality, significant shortage of human resources for health (HRH), and inadequate water and sanitation systems. Poor access to health facilities, lack of basic health knowledge, insufficient health awareness programs for inhabitants, and mental health problems among communities were pointed by the questionnaire respondents. Shortage of HRH and people's negligence for health were perceived as the major obstacles to improving the current health situation in Northern Province. The key informant interviews revealed that Sri Lankan HRH outside Northern Province had only limited information about the health issues in Northern Province.

It is required to develop and allocate HRH strategically for the effective reconstruction of health service systems in Northern Province. The empowerment of inhabitants and communities through health awareness programs and the development of a systematic mental health strategy at the state level are also important. It is necessary to provide with the objective information of gaps in health indicators by region for promoting mutual understanding between Tamil and Sinhalese. International assistance should be provided not only for the post-conflict area but also for other underprivileged areas to avoid unnecessary grievance.

Keywords: Post-conflict; Reconstruction; Health systems; Human resources for health; Sri Lanka

* Corresponding author at: 65 Tsurumai-cho, Showa-ku, Nagoya 466-8550, Japan. Tel.: +81 52 744 2113; fax: +81 52 744 2114.
E-mail address: mnagai@med.nagoya-u.ac.jp (M. Nagai).

0168-8510/$ – see front matter © 2006 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2006.12.001

1. Introduction

Regional conflicts are increasing throughout the world since the end of the Cold War. Public health problems in armed conflicts have been well documented [1,2], and health service strategies during the complex humanitarian emergencies were substantially established [3,4]. However, strategies for effective international assistance in transition periods from conflict to peace have not been well established. While a risk of resumption of conflict is still high, any international assistance in the health sector in this period should contribute to enhance peace-building efforts.

Since 1983, Sri Lanka had been in armed conflicts between the pro-independent militant Tamil group, named "Liberation Tigers of Tamil Eelam (LTTE)" and the Sinhalese dominant Sri Lankan government force. During the conflict, Northern and Eastern Provinces had been the main battlefield. The country has divided into two areas by the changing conflict front lines: the area mainly under the control of LTTE and the area under the control of government. United Nations High Commissioner for Refugees (UNHCR) reported that over 60,000 people lost their lives, 200,000 had fled abroad and nearly 80,000 were displaced within Sri Lanka [5]. In February 2002, the Government of Sri Lanka and the LTTE finally signed a cease-fire agreement. Although both sides have kept the cease-fire for more than 3 years, the peace negotiation has been disrupted since April 2003, thus a long-term prospect for peace is uncertain at present.

Sri Lanka is famous for its relatively sufficient basic health and educational indicators in comparison with other similar economical-level countries [6]. Even during the prolonged conflict, Sri Lankan people enjoyed the benefits of social services such as health and education. However, the degree of benefits was not equal between Northern and Eastern Provinces where the main inhabitants were Tamil, and other areas where the main inhabitants were Sinhalese [7]. After the cease-fire agreement, international donors have mainly focused their support on the former main battlefield, Northern and Eastern Provinces. This may cause the sense of inequality among Sinhalese, which may cause the stagnation of the peace process.

This paper aims to: (1) review the demographic health information of Northern Province in comparison with those of other areas in Sri Lanka, especially underprivileged areas not directly affected by the conflict; (2) detect unmet needs among health care providers and inhabitants in Northern Province; and (3) recommend a fair and effective health strategy for post-conflict reconstruction.

2. Methods

Demographic, health and health facility data of pre-conflict, in-conflict and post-conflict periods published by the Sri Lankan government and international agencies were collected and reviewed. Northern Province was selected as a representative of a directly conflict-affected area. This Province includes five districts: Jaffna, Kilinochchi, Mullaitivu, Vavuniya and Mannar. Kilinochchi district was administratively separated from Jaffna district in 1983, and its health data was bracketed into Jaffna district until 1991. Data of the national average and Badulla district in Uva Province was also collected for objective comparison. Badulla district was recognized as an underprivileged district by Sri Lankan people, although it was not a battlefield during the conflict.

Open-ended, self-administered questionnaires were administered among health care providers and inhabitants in Northern Province in October 2004 to detect unmet needs. We used purposeful sampling method, in which inhabitants and health care providers were selected to be representative of the variety of circumstances among those exposed to the conflicts. The main inclusion criteria of respondents were those living in or working for: (1) longstanding Tamil communities mostly controlled by LTTE during conflict; (2) the government-run "Welfare Centers" where registered internally displaced persons (IDPs) live; or (3) relocation/resettlement sites where former IDPs live.

The five-paged questionnaire was dispensed through the Sri Lankan government health sectors in Northern Province as well as several non-governmental organizations (NGOs) active in the health field in Northern Province. These organizations were instructed to deliver the questionnaires to health care providers and inhabitants who fulfill criteria mentioned above. A total of 71 questionnaires, 35 health care providers and 36 inhabitants, out of 120 disseminated (59%) were returned.