Report on Roundtable Discussion

Health and Education in Conflict-Affected and Fragile Contexts

Bridging the development gap and enhancing collaborations

USIP, Washington, DC – 31 May 2013

Purpose of the Roundtable Discussion

On May 31, 2013, the Inter-Agency Network for Education in Emergencies (INEE) Working Group on Education and Fragility, in collaboration with the Health and Fragile States Network (HFSN), held a Roundtable Discussion hosted by the United States Institute of Peace (USIP) in Washington, D.C. The aim of the Roundtable Discussion was to build linkages between the health and education sectors working in fragile and conflict-affected contexts and identify concrete steps to improve inter-sectoral collaboration. The broad questions that inspired the event were:

- How can the education and health sectors collaboratively address the challenges posed by conflict-affected and fragile contexts in the post-2015 world?
- How can the two sectors work together to strengthen state- and peace building processes in these contexts?
- How can the two sectors collaborate to effectively influence donors to prioritize funding to both sectors individually, as well as combined health and education projects and programs, in conflict-affected and fragile contexts?

Background

The role that education plays in conflict-affected and fragile contexts, including in state and peace building processes, is well documented. For example, a country which has 10 percentage points more of its youth in schools cuts risk of conflict by four percentage points. Similarly, there is a substantial body of evidence on the health sector's role in conflict-affected and fragile contexts. For example, by contributing to a stable demographic pattern and strong labor force ready to participate in the economic recovery of the state, the health sector plays a crucial part in the long-term peace building process.

The Roundtable Discussion was inspired by the awareness of the two main organizers that while the two sectors discursively recognize one another's contributions and the value of collaboration, they currently rarely collaborate, particularly in fragile and conflict-affected contexts. Collaborations thus far are narrow (frequently focused on specific health interventions carried out through the education system, such as hand washing or HIV/AIDS awareness), and are most often designed to meet general development needs, not the needs particular to contexts of conflict-affected and fragile states. How health and education delivery can work together to mitigate conflict and fragility and meet the specific challenges to both sectors that arise in those contexts has not been well-documented, nor have partnerships been common. What inspired the May 31, 2013 meeting was the shared belief within both communities of practice that collaborative work across sectoral lines in these specific contexts is both urgently needed and potentially critical to the effectiveness of each sector, both separately and jointly.

Three Key Issues and Possible Areas for Collaboration

Discussion groups considered how the education and health sectors had or could respond to a range of challenges and dilemmas around three issues particularly pertinent to health and education in conflict-affected and fragile contexts, namely governance, protection and human resources. The focus of the discussion was not to look just at intersections of the health and education sectors – such as public health, school health, early childhood care

and development, the potential benefits of good health on education and vice versa – but to explore the commonalities of the two sectors as they operate in conflict-affected and fragile contexts. Participants considered the following questions:

1. How have challenges and dilemmas in areas of governance, protection and human resources been dealt with in the two sectors in the past?
2. What are the areas with greatest potential for knowledge sharing and synergy between the sectors?
3. What recommendations does the group have for collaborative work between the sectors?

The following paragraphs summarize the discussions.

1) Governance

Points raised in this discussion included the following:

- Consensus is lacking about whether non-governmental organization (NGO)/non-state provision of services is detrimental to (or supportive of) state legitimacy. Experiences from the health sector indicate that international development partners can provide services through non-state, not-for-profit providers (e.g. NGOs) without undermining the state.
- Conflict sensitive assessments at the beginning of a project/program are crucial to successful implementation. (e.g. World Vision's two week, multi-stakeholder, sector neutral assessment)
- Better process and outcome indicators are needed, especially in the education sector. It is difficult to measure impact of conflict mitigation or state resilience in the short term, though it would be possible to measure people's perceptions more intentionally. Reliable quantitative data in the health sector has led to considerable funding.
- Lessons learned from the Global Fund and the Millennium Challenges Corporation related to governance could inform work in both sectors.
- Theories of Change in education assume that improved education leads to decreased violence and more state legitimacy, but the evidence for this is weak.
- Good governance is intrinsic to both sectors but frequently projects are focused on delivery of technical services and do not address governance issues such as management and leadership, information systems and information sharing, compensation and working conditions in the two sectors. Even the Cluster system fails to focus on governance issues.
- The current focus on "resilience" may obscure other issues and divert resources from basic requirements in the two sectors.

Suggestions for collaboration included:

- Improve knowledge sharing about each sector's work in crisis and conflict-affected contexts: The health sector utilizes the Sphere Project standards; the education sector utilizes the INEE Minimum Standards. Could or should the two sectors develop a common set of achievable objectives, particularly related to governance?
- Integrate conflict-sensitive approaches and principles in both health and education sector plans (joint advocacy initiative).
- Conduct simultaneous conflict assessments in both sectors to identify common issues, challenges and opportunities for collaboration from the beginning. For example, existing demographic health surveys are household surveys looking primarily at health issues, but these can also be used to look at education issues, as they already incorporate elements relevant to education.

- Collaborate on identifying potential unintended or under-researched consequences of work in these two sectors that either promote or mitigate conflict.

2) Protection

This discussion focused on the need in both sectors for protection from attacks on personnel, facilities, and those benefiting from services (students and patients). Five areas of common concern emerged:

- continued research needs;
- the role of the community;
- the role of the content of education (curriculum and materials being taught);
- psychosocial health; and
- the effects of attack: collaborative interventions responses.

Research and analysis are needed to understand the attacks on both sectors and any successful methods for addressing them, if available. Reliable evidence of the number and types of attacks still needs to be collected, analyzed and disseminated, especially to donors and state governments. This work is underway via the Global Coalition to Protect Education from Attack (CGPEA) and the Safeguarding Health in Conflict Coalition, both of which were represented at the Roundtable Discussion. The reasons for attacks are generally political, and are highly contextualized, which makes drawing general conclusions very difficult.

The community's role in protecting both education and health program activities from attack is critical and should be an area of focus. While the community can be part of the problem of attacks as well, community ownership of local provision of healthcare and education is critical to the protection of both sectors. Both sectors have evidence of communities' desires for health and education services. In education, for example, educators work to engage local communities, especially parents and Parent-Teacher Associations, in protection and monitoring of school safety. Finding synergies between the two sectors to improve community monitoring and protection could be an important area of collaboration.

Given that attacks are often politically motivated and that identity is so heavily involved in conflicts, the curriculum and content of education are critical areas to analyze to better understand conflict dynamics and how education contributes to conflict as well as how it can help to mitigate conflict.

Psychosocial responses to trauma in children emerged as a significant area of overlap between the two sectors. Mental health responses can be provided in schools, and teacher training to identify signs of trauma and refer students to health services is an area that can be jointly developed. A human resource gap currently exists in this area. Teachers and other education workers are well-placed, not so much to treat trauma, but to refer trauma victims to the appropriate healthcare workers. In some cases, teachers contribute to the trauma due to entrenched practices which could also be addressed by training and sensitization initiatives influenced by both sectors.

Finally, the two sectors should explore collaborative responses to attacks in order to reduce them, especially via advocacy and sanctions. Currently, examples of collaboration, successful or not, are not well reported (even if they are happening on the ground). Joint assessments and evaluations of how each sector resists and tries to reduce attacks would be useful, as would the joint development of recommendations for sanctions for those who attack the health and education sectors. Above all, joint advocacy seems like a promising area for future inter-sectoral collaboration, focused on decision-makers, among them perpetrators of attacks. Domestic, especially local level, approaches to protection should be studied to see if there are lessons from each sector that the other could utilize. Peer

pressure for common objectives could be used by representatives of each sector within each of the two relevant ministries (education and health). The two sectors can work together to develop advocacy messages and identify priority targets. More formalized ties between the two main protection coalitions, GCPEA and Safeguarding Health in Conflict, are also needed; the respective representatives committed to taking necessary steps towards this.

3) Human Resources

Four major areas of common concern for human resource development in both the health and education sectors in conflict-affected and fragile contexts emerged in this discussion group, as well as several areas for investigation and research. These four interrelated areas were:

- quality and appropriateness of existing education and training programs;
- gender;
- aspiration and leadership; and
- employment issues.

The quality and appropriateness of current education and training models are problematic for both education and health sector workforce development. The low quality of education, a key challenge globally, is particularly problematic in conflict-affected contexts with shortages in supply of qualified school graduates. Academic certification processes are flawed and do not always correlate with skills. Whilst secondary education is critical to long term workforce development, non-formal and short-term technical and vocational education and training is more appropriate to produce health and education workers than school-based education, particularly in refugee, post-conflict and other contexts where schooling has been disrupted and populations displaced. Lack of appropriate and effective in-service training also adversely affects workforce development in both sectors.

Maintaining gender balance in the workforce is a challenge in both sectors. In many conflict-affected contexts, fewer girls graduate from secondary school and fewer young women enter employment than boys and young men. This perpetuates a vicious circle: fewer female teachers and healthcare workers, means fewer girls and women can go to school or access healthcare. Among the serious issues that limits secondary education access of girls is security, particularly with regard to sexual predation in and on the journey to schools, and concerns for their safety and honor. The same security and honor issues are also faced by female teachers. Schools can be made safer and more acceptable for girls by increasing the number of female educators.

Closely related to the above concerns is that of aspiration: many marginalized and disadvantaged young people, especially but not only young women, have difficulties seeing a path or role for themselves in the health and education sectors. Both role-modeling and mentorship are useful strategies for workforce development. A parallel problem is that in some contexts young people's aspirations, focused on formal, government-salaried jobs, are too high: education and health workforce needs in conflict-affected and fragile contexts are not primarily for university graduates (doctors, graduate teachers).

Finally, health and education workers who have acquired the essential training and skills often cannot be employed where the needs are greatest due to irrationalities in the employment system, corruption, patronage systems, discrimination and failure to recognize the qualifications of returnees who received training outside the country.
The discussion group on workforce development identified the following needs and next steps:

First, identify successful interventions:

- Identify and research case studies to assess successes and failures of earlier post-conflict health and education reconstruction programs: Cambodia, Mozambique, Nepal, Indonesia, and Egypt projects were specifically cited.
    - What were interventions to rebuild the education and health sectors there?
    - Were there linkages between the human resource needs of the two sectors and secondary education goals? How did governments support (or not) secondary education?
- Research experiences with different forms of Public-Private Partnerships. For example, governments set learning standards first, then NGOs provide means.
- Identify interventions aimed at getting more female health and education staff (e.g. vis-à-vis gender, building walls around schools to allow girls to attend and women to teach; hiring husbands of women health care workers; including child-care in training, etc).

Second, support development of effective strategies:

- Identify non-formal education mechanisms that can complement more formal secondary education systems as potential 'catch up' for out-of-school youth.
- Support efforts at cross-country, South-South learning; weighing benefits of sending professionals abroad for learning.
- Find ways to ensure that government policy-makers (and donors) understand the centrality of the systems necessary to support human resource development in conflict-affected and fragile contexts. This includes connecting secondary education with employment opportunities and ensuring access and support for women in school and employment.
- Identify ways to ensure multi-year commitments from governments and donors, both in terms of resources and focus on quality, as the foundation for human resource development.

Conclusions and Recommendations

Across the discussions around the three issues, the following themes emerged as being pertinent for both the health and education sectors in conflict-affected and fragile contexts:

Inter-sectoral collaboration

Strong support was expressed for greater collaboration between the sectors that would be mutually beneficial. It was noted that a number of divisions separate practitioners – not only are the humanitarian and development sectors separated, but also the health and education sectors. Clusters in humanitarian settings are trying to work together, but face difficulties in obtaining donor funding for such collaboration. As a start, collaboration between the INEE Working Group on Education and Fragility and HFSN could provide a vehicle for each network to become aware of the existence and work of the other.

Participants from both sectors agreed on the need to identify and catalyze partnerships and align activities for the common purpose of improving basic services in health and education in conflict-affected and fragile contexts. Participants agreed that a major task is to identify and engage both governmental and developmental actors, to ensure that inter-sectoral work is integrated into national sector plans. The group agreed on the need to target specific organizations and fora to raise the level of attention to the need for health and education work in conflict-affected and fragile contexts to be better aligned. These could include relevant annual meetings; the International School Health Network and the Association for Supervision and Curriculum Development (ASCD)'s conference on "Contexts and Constraints in School Health in Thailand in August 2013; a panel at the World Bank at a side meeting; Overseas Development Institute and World Bank events in early 2014; Research Programme Consortium/Secure Livelihoods Research Consortium; Rebuild; and the Royal

Tropical Institute in Amsterdam (KIT) /HFSN website to reach the networks of both these institutions.

Research

There was a strong call for research to expand the currently weak or non-existent research base on health and education collaborations, actual and potential, specifically in conflict-affected and fragile contexts. Much of the discussion focused on the problem of state fragility and lack of legitimacy to citizens, and hence the relationship between state-building, nation building and service delivery. This area is a key concern for conflict sensitivity in both sectors; further collaborative research is needed on this. The group present agreed on the need to begin with the modest but concrete and doable goal of identifying a first research project with a likely donor to provide some of the findings and data needed to plan for future projects.

Funding and Advocacy

Partnerships and collaborations are necessary to attract more resources for inter-sectoral work. The need for evidence-based advocacy to promote inter-sectoral collaboration emerged strongly at the meeting, including selecting our messaging strategy and identifying audiences. Advocacy is necessary for all the other goals, including securing funding for research and joint programming, influencing the content of national health and education sector plans as well as the debate on the post-2015 agenda. One suggestion was to take a life-cycle approach in setting out objectives in proposals. By designing programs around the concept that a child is a whole being, health and education interventions could be considered together for the different phases of childhood: from early childhood development through to youth.

Agreed Next Steps

Short-term, June and July 2013

- Finalize the event report
- Identify priority actions

Midterm, June to December 2013

- Develop an agreed-upon joint agenda for research and advocacy related to collaboration between the education and health sectors in conflict-affected and fragile contexts
- Identify priority areas for research proposal development
- Identify potential donors, and strategize how and when to approach them
- Distribute report of Roundtable Discussion within networks and prepare for September/October INEE Working Group on Education and Fragility meeting held in Washington, DC
- Plan for a meeting to continue momentum, including a side meeting to the INEE meeting in Washington, DC (Participants of this meeting will be the Working Group's health and education advisory group, Steve Commins, and a few Washington, DC-based health in conflict experts)
- Develop an invitation list and agenda to support a follow up meeting in the UK for European stakeholders, which is tentatively scheduled for November 2013
- Determine ways to present these outcomes at events including World Development Report 2004 events at World Bank and at ODI in 2014

Annex I: Roundtable Discussion Agenda

Health and Education in Conflict-Affected and Fragile Contexts
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Roundtable Discussion
United States Institute of Peace
31 May 2013, 9:00a.m.-1:00p.m.

Time	Session	Location
8:30am – 9:00am	Registration and Continental Breakfast	Foyer
9:00am – 9:15am	**Introduction** Lili Cole, United States Institute of Peace Steve Commins, Health and Fragile States Network	Room 241
9:15am – 10:25am	Plenary Session **Education and Conflict/Fragility** Rebecca Winthrop & Elena Matsui, Brookings Institution **Health and Conflict/Fragility** Benjamin Loevinsohn, World Bank **Collaborations Between the Sectors** Nora Shetty, INEE	Room 241
10:30am – 11:15am	Breakout Sessions **Group 1: Protection and Resilience** Facilitators: Len Rubenstein, Safeguarding Health in Conflict Sarah Nogueira Sanca, Education Development Center **Group 2: Human Resources** Facilitators: Steve Commins, Health and Fragile States Network Lili Cole, United States Institute of Peace **Group 3: Governance** Facilitators: Derick Brinkerhoff, RTI Jane Wood, Creative Associates	Room 241 Room 214 Room 215
11:15am – 11:35am	Break	Foyer
11:35am – 1:00pm	Discussion and Proposed Future Steps	Rooms 241

Annex II: List of participants

Education Professionals

Marianne Baesa, INEE
Lili Cole, USIP
Catie Corbin, Creative Associates International
Noëmi Gerber, INEE
Liz Hume, FHI360
Elena Matsui, Brookings Institution
Rachel McKinney, Save the Children
Yolande Miller-Grandvaux, USAID
Diya Nijhowne, Global Coalition to Protect Education from Attack
Sarah Nogueira Sanca, Education Development Center
Alisa Phillips, World Vision
Nora Shetty, INEE
Howard Williams, Development Alternatives Incorporated (DAI)
James Williams, George Washington University
Rebecca Winthrop, Brookings Institution
Jane Wood, Creative Associates International

Health Professionals

Steve Commins, Health and Fragile States Network/International Medical Corps
Mary Lyn Field-Nguer, Creative Associates International
Dan Irvine, World Vision International
Benjamin Loevinsohn, World Bank
Len Rubenstein, Safeguarding Health in Conflict
Cecilia Sanchez, UNICEF
Annie Savage, Federal Emergency Management Agency (FEMA)
Ronald Waldman, George Washington University School of Public Health

Professionals with Experience in Both Sectors

Derick Brinkerhoff, RTI International
Kate Fleming, American Institutes for Research
Jeff Helsing, USIP
Daniela Lewy, Bloomberg School of Public Health
Jon Silverstone, Education Development Center
Sean Slade, Association for Supervision and Curriculum Development (ASCD)