

OCCASIONAL PAPERS

Rebuilding Health Systems and Providing Health Services in Fragile States

The international community has compelling humanitarian, political, security, and economic reasons to become engaged in fragile states. Health is an entry point for engagement because people living in fragile states are disproportionately affected by major health problems such as high maternal and child mortality, AIDS, and malaria, and improvements in health services help strengthen civil society and restore legitimacy to governments.

Effective engagement with fragile states depends on donor coordination and an understanding of health system challenges to inform the design of health programs and selection of interventions. Planning requires considering allocation (what health services are to be delivered), production (how the services will be organized), distribution (who will receive them), and financing. The criteria for selecting interventions to expand access to health services are their impact on major health problems, effectiveness, the possibility of scale-up, equity, and sustainability.

There are various options for donor financing and models of engagement with fragile states, but this support should always combine short-term relief with longer-term development. Stakeholders should aim not only to save and protect lives but also use their commitment over the long run to shore up nations' ability to deliver good-quality services to their citizens.

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 the use of resources better, and efforts to deal with the consequences of lack of coordination or long-term commitment to the process needed

to “fix” fragile states. The health of states, their people, and their health systems depends in large part on meeting urgent health needs, carrying out quick-impact and medium-term responses, and addressing the longer-term development of health systems.

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SECTION 1: Characteristics of Fragile States and the Importance of Rebuilding Health Services

This overview gives definitions of fragility, describes typologies used to analyze fragile states, and defines the six components of state functioning, while considering the limitations of any rigid framework for classifying countries because of their complexity and unique context. This introduction also enumerates humanitarian, political, security, economic, and public health reasons to become engaged with fragile states and explains why health is an entry point for engagement.

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 the government to work in the interest of the public and demonstrate fairness to all groups. Effectiveness means the ability of government to maintain security and order and 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, water, shelter, sanitation, health, and security—means that people feel betrayed by the government's ineffectiveness and inability to maintain order and provide for their needs. In their eyes, the government lacks legitimacy. Many post-conflict countries demonstrate these conditions of fragility. Fragility can also occur, however, when there is stagnation or chronic underperformance, or it may signify a country's downward spiral from declining performance to collapse of government and civil society because of conflict.

In fragile situations, institutions essential to meeting people's basic needs and looking after those in greatest need are nonfunctional. Some countries, especially in Africa, have never had functional governments and service delivery systems. This failure to provide basic services frays the social fabric. As a result, the mechanisms of last resort in the community—which represent the capacity of local institutions and the community itself to respond to dire community and individual needs, such as in response to disease outbreaks and natural disasters—can no longer assist. Local capacity to deal with those situations depends on a modern state-level organization with access to adequate resources. Either those resources have never existed or no longer exist, or violence and political instability have eroded the state's capacity to respond.

The forms of state fragility in one typology are (1) deteriorating state, (2) collapsed state, and (3) state recovering from conflict. Some analysts further segment the third category into post-conflict and early recovery stages, yielding four possible conditions of fragile states: deterioration, arrested development, post-conflict, and early recovery. Several of the categories of fragile states recognize that conflict is not a requirement for fragility; rather some countries are fragile states simply because they have been stagnant or chronic underperformers. A key element in distinguishing countries is whether the government is willing but unable to perform because of lack of capacity or unwilling to provide basic services. In states where there is an unwillingness to provide services, such as Zimbabwe or North Korea, different analyses and responses are required.

Nabarro (2004) gives several characteristics common to most fragile states: first, there has often been a conflict that has resulted in the destruction of lives, property, assets, and livelihoods. Second, instability has resulted in the risk of violence to and intimidation of those not yet affected as well as those already affected by violence. Third, trust, which is critical for communities and societies to move forward, has broken down.

Typologies may be useful as a starting point for discussion of fragile states, but greater sensitivity to a particular state's situation and understanding of the root causes of that fragility are

necessary to be context-specific. Such analysis is not only helpful in classifying fragile states but also facilitates knowing how to work within different contexts.

A particular state may also exhibit fragility in multiple forms. While it would be simpler to create a matrix and put countries into clear categories, in reality they do not always precisely fit all the characteristics of a particular category of fragility. While commonalities can be identified, fitting all such states into categories is a futile exercise, because each country has particular features that color its state of fragility.

Conflict and Poverty Are Not the Only Causes of Fragility: Papua New Guinea

“Papua New Guinea is emerging as a fragile state not because of armed conflict or absolute poverty—its per capita GDP is higher than Pakistan[’s]—but because of a declining economy linked to poor governmental controls and policies, maladjustment to its inherited democratic institutions, a decentralized governance system ill-equipped to cope with the demands for rural social services, the worst HIV epidemic in the Pacific, and an escalating crime rate fuelled by rampant arms smuggling.” (Malau 2005, p. 4)

The Challenge of Using Typologies for Fragile States

“Based on the level of fragility, subtypes (weak, failing, recovering) can be identified. For practical decision making in development cooperation these subtypes have yet to become useful. More decisive than the subtypes appear to be the root causes for the fragility of a given country.” (BMZ/GTZ 2006, p. 2)

Summary: What Fragile States Lack

- **Effectiveness** in delivering core functions of government
 - **Capability** or capacity for governing
 - **Willingness** to govern
- **Legitimacy**: representative and accountable government

WHAT ARE THE COMPONENTS OF FRAGILITY IN HEALTH SYSTEMS?

Widely accepted definitions of fragility involve two main elements whose deterioration contributes to the failure of the state: effectiveness and legitimacy. Discussions that focus, therefore, solely on the presence or absence of fragility fail to recognize that fragility refers to more than one component of a state's functions. Identifying the key structural elements that make up a state also helps us identify a spectrum of options for dealing with fragile states.

Such a framework can be used to identify the specific components of fragility and to analyze a single country or small group of states in an ideologically neutral way. This framework provides a fluid and realistic set of possibilities for describing the wide variety of fragile states. Because these states are constantly changing, they also have the potential to move in and out of fragility. Focusing on the elements of government that apply to the health sector, the six basic structural components of a state are:

- stewardship
- accountability
- delivery of essential services
- resource management
 - human resources
 - financial resources
 - facilities
 - drugs, supplies, and commodities
- financing
- security

Stewardship refers to who owns or controls the assets and resources of the health sector. It

also concerns governance of the health sector, control of essential resources, and determination of the direction of the health system.

Accountability refers to the transparency with which transactions occur, resources are allocated, and money is spent. It also implies accountability for the way resources are used—not just financial resources but the allocation of human resources to various functions. That is, does the health system focus primarily on hospital and curative care or is it solidly based on primary health and preventive services?

Delivery of essential services refers to operation of the elements of the health system that provide health services, whether in fixed facilities, such as health centers, clinics, outpatient departments, and hospitals, or via mobile or outreach services and targeted campaigns such as national immunization days.

Resource management refers to the operation of the health system in regard to who manages the operations of the health facilities and the health system through the Ministry of Health. The resources managed for the health sector include health facilities, financial resources, human resources for health, and training and health research institutions.

Financing refers to who pays to provide health services and where the money coming into the health sector flows. Finances for the health sector come from private as well as public sources, including out-of-pocket payments, nongovernmental organizations (NGOs), and third parties. This financing encompasses both recurrent, or operating, costs and capital costs. Those paying for health services have a great deal of influence on how the health sector operates.

Security refers to the necessity for people to go about their daily lives and earn their livelihoods freely, without fear of violence.

Although states vary in regard to these components, they can usually be analyzed according to their current condition and the direction in which they are moving (i.e., toward greater or reduced fragility). Hence one might call a state “somewhat fragile” or “extremely fragile.” Classifying a country in light of both legitimacy and effectiveness is more useful than looking at a single dimension. For example, it is possible for a national government to have limited legitimacy due to political events yet continue to be reasonably effective in delivering essential services.

Typologies for fragile states can be used but should not be rigidly applied for categorizing countries without making distinctions among them, using the six components defined above. For example, country A exhibits some elements of a collapsed state with regard to accountability, resource management, and financing but shows some positive signs in delivering services and exhibits some elements of stewardship.

WHY ARE FRAGILE STATES IMPORTANT TO THE INTERNATIONAL COMMUNITY?

The international community is concerned about fragile states for several reasons, the first being the magnitude of the problem. Almost 50 states have been identified as fragile. Millions of people are affected because:

- 15% of the developing world’s population reside in fragile states;
- one-third of the world’s poor are found in fragile states;
- only a quarter of global aid is focused on fragile states.

The international community’s concern about fragile states is also humanitarian: fragile states are seeing human development decline rather than advance. These concerns led to the devel-

opment of the Millennium Development Goals (MDGs), which represent an attempt to help all nations reach a baseline of development. However, in Africa alone, few, if any, countries—whether they are considered fragile or not—are on track to reach the MDGs. Fragile states in particular are seeing human development decline rather than advance. In chronically nonperforming states, human development may regress over a long time. Humanitarian concerns also emerge during times of human crisis or natural disaster.

The international community has legitimate political, security, and economic reasons for become engaged with fragile states. Fragile states represent instability that can spread to pose threats throughout a region, destabilizing neighboring countries. Fragile states can be a source of mass migration of people across national boundaries. Internationally, there is also concern that fragile states can threaten global security by becoming incubators for international terrorism and crime. Fragile states may be a drag on the global economy, so there is interest in increasing global wealth and productivity by helping fragile states.

The international community also has concerns about fragile states because of the ability of diseases to quickly spread internationally. Fragile states are home to many outbreaks of these diseases and pose challenges to effectively address them: the majority of Ebola cases in recent years have occurred in Sudan, northern Uganda, the Democratic Republic of Congo, and Congo Brazzaville. There are certain diseases of international interest—either because there are efforts to eradicate them (guinea worm, polio), because they have global public health significance (SARS, avian influenza), or because they are virulent and without cure (Ebola, Marburg).

So the international community has humanitarian, political, security, economic, and public

health reasons to become engaged with fragile states. If the international community leaves fragile states to fend for themselves, it is unlikely that

they will be able to create the needed capacity on their own and the environment for positive change. Hence, outside assistance is required.

Summary: Why Fragile States Are of Concern to the International Community

- They are often the sources of mass migration.
- They may give rise to violence (terrorism and international crime).
- They may become repositories of disease.
- Their economic situation affects the global economy.
- A state's collapse can threaten regional security and development.

WHY IS HEALTH AN ESSENTIAL PART OF ASSISTING FRAGILE STATES?

The political situation of fragile states can have a shocking impact on the health of a country's population. The burden of disease and the mortality levels experienced by the populations of fragile states are extraordinarily high:

- More than a third of maternal deaths worldwide occur in a fragile state.
- Half of the children who die before age five live in a fragile state.
- Death rates of more than 1 death per day per 10,000 population occur in fragile states.
- A third of the people in fragile states are malnourished.
- A third of people living with AIDS are citizens of fragile states.

- Malaria death rates are 13 times greater in fragile states than in other developing countries.

The high disease and mortality rates in these states are in themselves causes of fragility. But the state's fragility—its lack of effectiveness in delivering social services—is also a cause of poor health indicators. The collapse of the health system in these countries makes it easier for disease and epidemics to spread. As a result, the number of preventable deaths is much greater than it should be, and the burden of morbidity is so heavy that states cannot recover without outside assistance and intervention.

There are several reasons why we should be involved in providing health services in fragile states. First, there is a humanitarian imperative to act in the face of crises that result in high rates of disease, mortality, and destruction of food sources, people's homes, and other basic survival needs.

Fragility Negatively Affects the Health System: Lao People's Democratic Republic

“The poor performance of the health sector is a reflection of the wider structural problems of the Lao political economy, the lack of a vibrant civil society, and the lack of incentives within the civil service system. The government has not yet demonstrated that it can effectively raise revenues, manage public expenditure, and provide services on the basis of community needs.” (Toole 2005, p. 5)

Second, health service delivery may be a good entry point for becoming involved with a fragile state and addressing the causes of fragility. Stabilization of a public health crisis is a necessary precondition for further work on political stabilization and economic recovery. Health services can lead to involvement with both the government and civil society. The engagement of entities such as NGOs, faith-based organizations, and global health partnerships plays a significant role in expanding access to basic health services. Health services can also provide an impetus for engaging civil society in improving both the effectiveness and legitimacy of the government.

Providing health services has ramifications that go beyond satisfying the human need for such services. Health services, as well as education and development of infrastructure (such as roads and electrification), are an important part of strengthening the state. The extension of ba-

sic services to greater proportions of the country meets the political imperative to give the populace a “peace dividend,” which demonstrates the value of the re-established government.

Positive developments in health service delivery can not only promote optimism about the future but also serve as a basis to move the government toward reform in other areas—political, social, economic, and security. Thus assistance in health can serve as a platform for the initiation of longer-term development activities.

Finally, health service delivery may help prevent states from slipping into violence. Fragile states may not have experienced violence in the past but are still susceptible because the root causes of fragility are still apparent. Positive results in health service delivery can demonstrate a “reform dividend” and provide the fledgling government more time to pursue further reforms and betterment of people's lives.

Health as an Entry Point: Nepal, Guatemala, and Côte d'Ivoire

“Due to the undisputed importance and political neutrality of health and health services, alignment in health-related development cooperation in fragile states appears to be easier than in other sectors. It might thus be particularly well suited as an entry point (or a field to stay engaged) in fragile states.” (BMZ/GTZ 2006, p. 2)

Summary: Why Health Is Important to Address the Causes of Fragility

- Protecting human life: Reduction of morbidity and mortality is a humanitarian imperative, with positive effects that range from reduced spending on curative care to improved productivity.
- Serving as an entry point: Health services can be an entry point for engagement with governments and civil society.
- Demonstrating results: Health serves as one element of the “peace dividend” in post-conflict countries.
- Reducing fragility: Good health services enable governments to be more effective and increase their legitimacy.
- Breaking the cycle: Health services can help break the vicious cycle in which fragility contributes to poor health, and poor health can cause fragility.

SECTION II: Health Service Delivery and Health System Development in Fragile States

As the previous section illustrates, the magnitude of the health problems faced by fragile states presents immense challenges. While disease outbreaks or high mortality rates must be the short-term focus in many fragile states, it is imperative to start planning at the same time for the transition to longer-term development of the health system so it can be rebuilt while the most urgent health interventions are introduced. This dual focus requires addressing the elements of a dysfunctional health system and how it can be totally rebuilt while dealing with immediate health crises and priorities.

WHAT ARE THE NEEDS OF A FRAGILE STATE'S HEALTH SYSTEM?

The deficiencies of the health system in fragile states can be characterized in a number of ways:

- **The health system lacks infrastructure.** There are insufficient facilities, human resources for health, equipment and supplies, and drugs.
- **The health delivery system is in disarray or dysfunctional.** Since the system lacks coordination or oversight, services are accessible primarily to urban populations.
- **The government is not providing health services.** For the most part, health services are provided by non-state providers, with little policy direction or monitoring by the government.
- **There is a lack of equity in the provision of health services.** In the services that do exist, there is great inequity, especially for secondary and curative services. Few public health services exist for the poor.
- **There is no system for establishing policy.** The health system is like a ship without a rudder—there is no clear course to follow. Providers of care have been free to offer whatever services they desire and to provide nonstandardized training to health workers.
- **Implementation of policies is non-existent.** National policies have not been established to steer the health system. The policies that do exist are not followed, since there is insufficient oversight of the health sector and of the implementation of policies.
- **The health system operates without adequate information.** There may be no up-to-date information about which diseases are endemic, what kinds of and how many health facilities exist, and where health workers are located.
- **Few functional management systems are in place.** Without systems, there is no basis for developing budgets, tracking expenditures, assessing workloads, tracking the availability of human resources, or carrying out disease surveillance.
- **Management capacity is lacking.** There is a shortage of managers skilled in managing the health system, health facilities, and human resources for health.

These dysfunctional elements and deficiencies in the health system will be found in most fragile states. While they will not manifest themselves in the same way in each situation, the general systemic problems in the health system are typical. It is not just the limitations imposed

by infrastructure problems, such as damaged hospitals or lack of clinics, but the inability of government to assess the situation, develop appropriate policies, and then provide the leadership to manage the necessary reforms and

changes to the health system. So in determining what interventions and assistance can be provided to the fragile state, the real challenge is the requirement to address these interlinked problems concurrently.

Summary: What the Health Systems of Fragile States Lack

- Infrastructure: health facilities and equipment in operable condition
- Resources: finances, trained staff, drugs, supplies
- Functioning delivery system
- Coordinated provision of health services
- Equity of access to health services
- Policy-making mechanisms
- Implementation and regulation of policies
- Accountability
- Information for planning and management
- Management systems
- Capacity to manage the health system, health facilities, and human resources for health

WHAT IS DIFFERENT ABOUT WORKING IN THE HEALTH SECTOR OF A FRAGILE STATE?

During periods of conflict or weakening of social structures, the system for health service delivery deteriorates, leaving health professionals little to work with. Moreover, many trained health workers migrate during conflicts to safer, more supportive work environments in other

countries. The result is most fragile states suffer a critical lack of health professionals.

In countries whose development is arrested and in collapsed states, the lack of staff and infrastructure makes it difficult to undertake initiatives to gradually improve the health system. In unwilling states, it is nearly impossible for donors to take action except in severe emergencies or humanitarian crises.

Difficulties of Working in Fragile States: Nepal, Guatemala, and Côte d'Ivoire

“There is no way of denying that working in fragile states is considerably more expensive than working on similar issues in a more stable environment. . . . A major difficulty when working on service delivery in fragile states is the **security situation**. Most fragile states are characterised by insecurity at least in part of the country; the behaviour of security forces themselves is sometimes not entirely predictable. Initiatives to improve service delivery must therefore be carefully planned and implemented to avoid unnecessary risks to beneficiaries, partner organisations, local and international staff.” (GTZ 2006, p. 4)

Most people who work in international health development focus on the long-term development of health systems. However, often long-term development is a secondary concern for donor governments, which have more immediate objectives, such as responding to humanitarian crises or attempting to keep such states from being incubators for terrorism.

To make the transition from relief to development, countries must move through a number of stages, as illustrated in Figure 1.

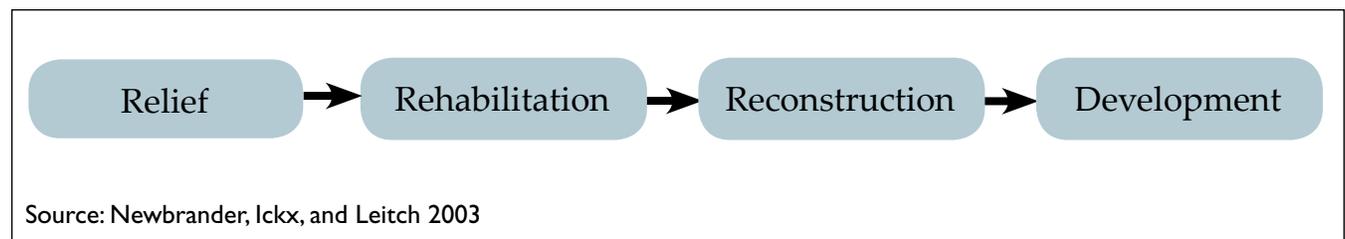
These stages of transition apply not only to post-conflict and recovery states but also to deteriorating and arrested development states. However, these stages do not follow a linear progression in which one stage needs to be finished before the next can start. For instance, Afghanistan experienced a prolonged state of political emergency, aggravated by natural disasters such as earthquakes, floods, and a prolonged drought that plagued large parts of

the country in 2002. Areas that enjoyed relative stability after the departure of the Taliban demanded rehabilitation and longer-term planning. However, in areas characterized by war and insecurity, only emergency relief services were initially feasible.

The government—in all sectors, but especially in the social sectors—was challenged to secure peace and lay the groundwork for the establishment of civil society by showing the people that it could get results. At the same time, the government had other urgent needs to address. For instance, due to persistent drought and continued warfare, many people in remote areas such as the Hazarajat faced potential starvation.

The Ministry of Public Health (MOPH) had to provide relief services to address the emergency health situation, but it also had to plan for the future, which included rebuilding and sustaining a national health system. The MOPH made clear its understanding of the massive

Figure 1. Stages for Moving the Health System from Emergency to Development



challenges facing it, acknowledged its capacity limitations, and requested technical assistance and support from the international community to move beyond relief to rehabilitation and ultimately to the redevelopment of the country's health system (USAID and MSH 2006).

WHICH INTERVENTIONS IN FRAGILE STATES' HEALTH SYSTEMS ARE PRIORITIES?

The path for governments and donors to follow to move beyond stagnation or conflict depends on the environment. The first priority is to extend services to an increasing portion of the population to promote equity and address the most pressing health problems. Because local resources will be inadequate to initiate these interventions, donors should be ready to assist in providing resources and remain engaged for the long term. They play a critical role in providing the resources for technical assistance, initial support of recurrent costs, capital investments, and training of human resources.

Although it will be difficult to make rapid progress, the successful implementation of an agreed-upon package of health services will greatly improve the health status of the population by increasing access to basic and essential health care at the community and district levels. Success, however, requires important prerequisites in the general environment—peace, security, and a stable government—as well as in the health sector: establishment of national health policies to govern the priorities of the health system, sufficient human resources, proper health system structures, adequate financing, effective management systems, and a functioning referral system for health services, as outlined below.

Addressing urgent disease situations and health needs. It is critical to respond to humanitarian crises and health needs to establish

government legitimacy. Disease prevention, especially immunization, is a critical area in which to begin.

Gathering information. Because the state of the health system and the resources available are not known, it is important to carry out a rapid assessment of health resources—facilities, equipment, human resources, and drugs and supplies—and the nature and extent of disease problems. For instance, it may be necessary to conduct studies, surveys, and assessments to gather information on maternal mortality, nutrition, national mortality, and injuries. In the meantime, the lack of such information means that planning decisions and prioritizing will take place using data that were usually collected many years before the decline into fragility. Additional data will be needed to determine service capacity and coverage, demographics and the epidemiology of populations, and governance of health facilities and programs at both the national and local levels.

Creating a basic package of health services. The cornerstone of the emergence of a functioning health system in a fragile state is identifying a basic package of health services that addresses the most common health problems at all levels and focuses on priority interventions for reducing mortality and morbidity. This basic package will also establish the vision of priorities that will guide the health sector in the future. Its rapid implementation country-wide is important not only to improve health but also as an element of the formation of a stable civil society.

Developing policies, strategies, and plans. The government will need to begin by prioritizing, developing its strategy so that donors may begin to align with it when they move from dealing with the humanitarian crisis to designing and redeveloping the health system. This

task includes laying the foundations for the longer-term development of the health sector by developing policies that will guide how the health system is managed and the roles that government, NGOs, and the private sector will play in providing services and medicines to the population.

Developing human resources for health.

Managing the health system begins with managing human resources for health. To have the capacity to do so requires having the right cadres of health workers in the correct numbers, a system for proper training, and a basis for certifying and maintaining the certification of workers, all of which will promote improved quality of care. In addition, the government must deal with health providers who remained in the country during the difficult years and whose training may not be adequate. Health providers may have received different forms and levels of training, and there will be a need to standardize the requirements of the system. Adequate numbers of managers for the health system and health facilities will also need to be developed.

Ensuring regular supply of essential drugs.

The leading causes of morbidity and mortality in fragile states can be prevented, treated, or at least alleviated with cost-effective essential drugs. So it is important that good-quality essential drugs be available, affordable, and used rationally. There can be measurable health improvements with greater access to and more rational use of drugs.

Financing services. What services should be funded? Initially, the services that will have the greatest impact on the most crucial health indicators should be funded. To promote equity and the government's legitimacy, it is also essential to deliver basic curative services, as well as public health preventive services, to a wide segment of the population. As work

begins, the question of who will fund services after the crisis has passed must also be addressed. Knowing the length of funding and the reliability of the funding stream is critical for assessing and planning for sustainability.

Redeveloping the health sector. The Ministry of Health may need to be reorganized to fit the new circumstances and the vision of the health sector. This reorganization may include decentralizing functions that were formerly centralized. Reorganization will also have to be addressed in the larger political context of the national government's plans for provinces or states and the degree of autonomy they will have, including their degree of control over financial and human resources.

Rehabilitating and reconstructing health facilities. Whether the upgrading of health facilities is required due to long periods of neglect in collapsed states or damage from national disasters or war, health facilities will have to be rehabilitated or reconstructed. This is a form of aid that many donors are pleased to undertake. It is important that the government be proactive in determining whether facilities should be rebuilt or relocated to areas where there is greater need. This decision will have to be balanced with donors' preferences; for example, they may wish to build only in secure areas, which may have the least need for new facilities and services.

Coordinating donors. The need for donor alignment—using donor resources and activities to support the priorities of the host government—is enormous. Orchestrating the interventions of donors so that they are complementary rather than competing will strengthen coordination among donors as they seek to make the most of their resources. Attempts to align and harmonize donors provide an opportunity to strengthen relationships between bilateral and multilateral agencies.

Donors must find appropriate instruments that will allow them not only to provide long-term support to the health sector but also to reinforce the predictability of that support. In doing this,

donors will reduce the volatility of funding for the health sector while increasing the need that fragile states have for predictability.

Summary: Priority Tasks for Assisting the Health Ministries of Fragile States

- Address urgent health needs.
- Gather information.
- Create a package of basic health services.
- Develop policies, strategies, and plans.
- Develop human resources for health.
- Ensure a regular supply of essential drugs.
- Finance services adequately.
- Redevelop and reform the health sector.
- Rehabilitate or reconstruct health facilities.
- Coordinate donors.

SECTION III: Health System Development in Fragile States: Challenges and Lessons

It is imperative for the international community to take action when a humanitarian crisis such as a natural disaster is looming. Action is less pressing when a deteriorating state is gradually falling into fragility. Once the crisis has begun to abate, there is a gradual shift in efforts and resources from emergency to development. The resources available may decrease over time, because much of the initial donor funding will go to addressing the humanitarian crisis and the initial early period of development, as suggested by Collier and Hoeffler (2002). However, this transition to development can be difficult, as the Democratic Republic of the Congo has found.

Striking a balance to satisfy both their short-term interests (humanitarian) and their long-term interests (political and developmental) presents donors with a challenge, and donors often have different mechanisms for dealing with these two elements. Hence, donors themselves often have difficulty aligning the humanitarian and the development support and interventions that they can offer. Donors do not always seamlessly shift their activities and attention as a fragile state moves from being in crisis to its requirement for longer-term

development. It has been noted that the transition from emergency to development is often handled poorly by donors. Frequently their assistance is from two separate funding streams. This means that a predictable, long-term funding flow from donors for a fragile state is anything but smooth.

Because health is part of a larger picture, donor actions with the Ministry of Health should not make drastic changes with political implications. Instead, donors should restore, repair, and build on the health system elements that worked well prior to fragility. In post-conflict countries the humanitarian crisis often persists and there is not a clear transition from emergency to development. Rather relief and development need to take place at the same time.

There is also a risk that as humanitarian assistance fades, there may be a gap between the crisis and development phases if development has not already begun. To make this transition smoothly, donors need to develop flexible aid instruments that can deal with humanitarian crisis and development simultaneously.

The Challenge of Transitioning from Humanitarian Crisis to Development: Democratic Republic of the Congo

“The biggest and most immediate threat to establishing the ability of the DR Congo’s Ministry of Health to effectively lead and manage a health system capable of delivering appropriate services to its population is a political one. While many components of donor assistance have been designed with the intention of consolidating the peace process, the health sector basically consists of two kinds of programs: continuing humanitarian assistance in conflict-affected (or formerly conflict-affected) health zones, and longer-term efforts to develop a ‘routinely functioning’ health system.” (Waldman 2006, p. 28)

Demonstrate commitment. Rebuilding a health system and ensuring the provision of rudimentary health services requires donors to look beyond the immediate humanitarian crisis that may have been the impetus for the entry of a donor. Once there is an element of stabilization and the crisis has receded, there is a natural tendency for donors to move on to other humanitarian crises. However, if a fragile state is to be truly helped, any progress that has been made must be sustained through commitment of donors for the long term.

Mechanisms for support. In fragile states, working directly through the government is very difficult due to lack of capacity and non-existent infrastructure and systems. The lack of absorptive capacity to effectively manage the flow of aid makes it important for donors not only to address the “quick impact” issues but also to build the capacity of the government by providing technical assistance and helping develop a policy process.

Some believe it is preferable to promote an “economic business model,” in which a donor, in consultation with the government, uses the private sector—nonprofit, for-profit, or both—to provide most of the goods and services needed. The question is whether donors’ use of the private sector strengthens the economy and the ability of the government to be effective in delivering services or weakens the government’s legitimacy in the eyes of the public, which may see NGOs and private entities delivering services and not credit the government for coordinating the provision of those services. NGOs and the private sector provide substantial portions of the health services in developing countries, so it would be unusual not to expect the same in fragile states where the government is unable to provide services. Financial incentives can be used to engage NGOs and the private sector in providing services, scaling up existing services,

improving quality, and moving services out to underserved areas. Use of the private sector also quickly moves the government into its greater role as steward and overseer of the health sector.

THE ROLES OF DONORS: ALIGNMENT AND HARMONIZATION

Donors play many roles, and donor concerns about health may also reflect international political concerns, resulting in large investments in the health sector, for various reasons. Humanitarian disasters encourage donors to help prevent mortality and morbidity. Donors may also seek to develop a health system for the country that will be effective, appropriate and sustainable. Or donors may be involved in several sectors and see health in the broader context of assisting a country to improve its security, stability, governance, and economy.

Donors have a significant role to play in supporting the actual delivery of health services in fragile states. Their role is not limited to financial assistance, however, but encompasses their ability to engage entities that will work with civil society—such as NGOs, faith-based organizations, and global partnerships as well as the private sector—to coordinate the resources and activities that will achieve the objectives of service delivery.

Donors also have a role to play in developing relationships and trust between the recipient country and the international community. For instance, one or two key donors may organize joint donor missions to engage other partners with the host government.

In countries that are willing, the government’s health ministry will need to establish mechanisms for coordinating work among donors. Alignment and coordination in states that are unwilling to cooperate and provide services to their popula-

tions is a challenge for donors. In these situations, non-state actors such as the World Health Organization may be called upon to undertake the coordination role on behalf of donors.

Donors and multilateral organizations must determine which issue to address first: eliminating the factors that cause fragility or improving the health of the population. If it is the former, the question is: “How will health services be structured to have the greatest impact on the root causes of fragility?” If it is the latter, the question is: “What services will have the greatest effect on the most critical health indicators?” In either case, delivery of primary health care to a wide segment of the population is important for equity and will have a bearing on the legitimacy of the government.

In the short term, it is crucial to identify the population that lacks ready access to the most basic health services, in order to extend health services as quickly as possible to areas where they do not exist and provide emergency drug supplies to areas where medicines are urgently needed. Box 1 describes how this approach was carried out in Afghanistan.

Principles of engagement. The principles of effective engagement in fragile states include actions and guidelines to direct the involvement of donors and providers of technical assistance in the health sector (see Box 2). It is imperative to act quickly to support the health system in addressing a humanitarian crisis. That immediate action should not override the

need to systematically assess the health sector, propose creative solutions, find the funding needed, and establish ongoing assessment and flexible means of responding to changing circumstances. Because the changes required are systemic and thus are extremely challenging to implement, a longer-term commitment is also required to ensure that there is sufficient time to develop the institutional capacities required to create real and sustainable change.

The aim of assisting fragile states is not only to overcome the immediate crisis, but also to use international engagement to develop national entities that will build a legitimate, resilient state that is able to meet the needs of its people. Only by working in this way will fragility be a passing situation for the government and health system rather than a permanent condition. This development requires constructively engaging the leaders of the health system in assessing the situation, defining the vision of where they wish to go, and developing a strategy for moving from the present to the desired state for the health system and health status of the population. Similarly, implementing that strategy requires engagement of the state’s leaders and citizens in defining a shared vision and the means to move toward it. This vision depends on a long-term view that addresses issues such as system development and sustainability. The summary box on p. 20 lists the actions needed to develop an effective health system that is sustainable and can deal with the challenges it will face over time.

Harmonization and Alignment: Kyrgyz Republic

“For the reforms to be both comprehensive in a systems approach, and tested in flexible increments, a high level of donor coordination was required. . . . This degree of donor coordination appears significantly higher than in other countries in similar situations. Donor collaboration was not automatically present from the outset; in fact it required significant work by individuals, and agencies such as WHO.” (Morgan 2005, p. 10)

Box 1. First Priorities in Afghanistan

Expanding Health Services

Throughout the decades of conflict, nongovernmental organizations (NGOs) became the principal providers of health care in Afghanistan. In 2002, almost all health facilities were receiving support from both the government and NGOs, with the NGOs owning close to 50% of all health facilities and providing some form of support to almost 80% of them. Using a rapid implementation process, the Ministry of Health (MOH) worked with its donor partners to establish a system for providing performance-based grants to these NGOs to expand delivery of basic health services to underserved areas and to improve the quality of services. In this system, health centers established targets for achieving a set of health service delivery objectives and receive payments based on their successful achievement of those objectives. These grants involved not only providing money but also dealing with critical issues such as training health professionals, obtaining drugs, and providing preventive as well as primary and curative services.

Providing Essential Medicines

Recognizing that high-quality medicines—continuously available and appropriately used—are essential to providing effective health services and developing public health programs, the MOH made the distribution of essential medicines a priority. However, because of the need for a rapid response, the MOH, with partner support, incorporated provision of drugs into the grants structure so that NGOs receiving grants to expand services would have the medicines they needed to deliver those services to a wider population.

In addition to providing drugs, the partners worked with the MOH to help establish the national essential drugs list and policies, improve drug management, and create an essential medicines and therapeutics committee to develop guidelines for drug donations. These efforts allowed the Ministry to respond to urgent needs while laying the groundwork for future policy decisions and development of the pharmaceutical sector in Afghanistan under its leadership (Newbrander, Ickx, and Leitch 2003).

This example illustrates how immediate needs—expanding service delivery and the availability of drugs—were met while the MOH and its partners undertook the longer-term capacity building of the Ministry so that it could develop appropriate essential drug policies and regulatory bodies.

Box 2. Principles of Effective Engagement in Fragile States

- **Collection and analysis of information:** Critical information about needs and existing resources must be gathered in a timely manner, and the context and factors that impact service delivery have to be analyzed to underpin the design of sound programs that are relevant to the context;
- **Creativity and flexibility:** Programs must be designed creatively to find new ways to overcome obstacles and constraints. Plans must be flexible so the programs can be easily adjusted to changing circumstances and as additional information becomes available;
- **Funding:** New funding tools and streams will be needed to improve the transition from humanitarian to development funding and increase the predictability of funding;
- **Implementation:** It is necessary to have experienced technical experts available for extended periods to assist the health ministry with analyzing information, formulating policies, designing systems, and developing mechanisms for implementation;
- **Monitoring:** Assessing progress compared to plans allows managers to make changes in programming and implementation;
- **Harmonization and alignment:** Good coordination with other donors to facilitate a common approach and alignment with the priorities of the government are important;
- **Commitment to long-term funding and support to build the health sector.**

Summary: Lessons for Donor Interventions in Fragile State Health Systems

Strategy

- Seek to have a **positive impact** on the lives of those in need.
- Build the **capacity** of government and non-state providers.
- Promote **equity**.
- Consider **sustainability** in the light of state fragility.
- Have the **adaptability** to recognize changes in environments and develop appropriate responses.
- Promote **transparency**.

Engagement

- Provide **long-term expert presence** on the ground.
- Make sure staff are experienced and have the **appropriate range of technical skills**.
- Emphasize **accountability for results**.

Financing

- Show **reliability** by making a commitment to long-term financing.
- Build in **flexibility in financing** from relief to transition to development.
- Be willing to cover **recurrent costs**.
- Ensure that **equity** concerns are met before financing a program.

Implementation

- Start with a **package of basic health services** and expand the range of services over time.
- Promote **system development**.
- Make **decisions based on evidence**.
- Conduct regular **performance monitoring**.

SECTION IV: Challenges of Health Service Delivery in Fragile States

To make a real difference in fragile states, it is necessary to improve health service delivery. Improved health services will have a significant effect on the lives of the poor and rural communities, and effective health service delivery will help create legitimacy for the state.

The rapid roll-out of affordable, accessible, and high-quality health services can have a major impact in demonstrating some of the dividends of peace, stability, and good governance which, in turn, contribute to the legitimacy of government. Providing incentives for equitable provision of health care can influence government policy and behavior, resulting in more attention to equity issues in general. Technical assistance and capacity building can help lay the foundation for a functional health care system and the management capacities required to sustain this element of state responsibility over the longer term. Each of these goals must be explicitly planned for, and in many situations there will be contradictions between different goals, so strategic choices have to be made.

These tasks are challenging, however, not only because of the environment in a fragile state but also because, as the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development points out in “Service Delivery in Fragile States: Advancing Donor Practice” (2005c), health service delivery must contend with issues of politics, policy, and technical implementation.

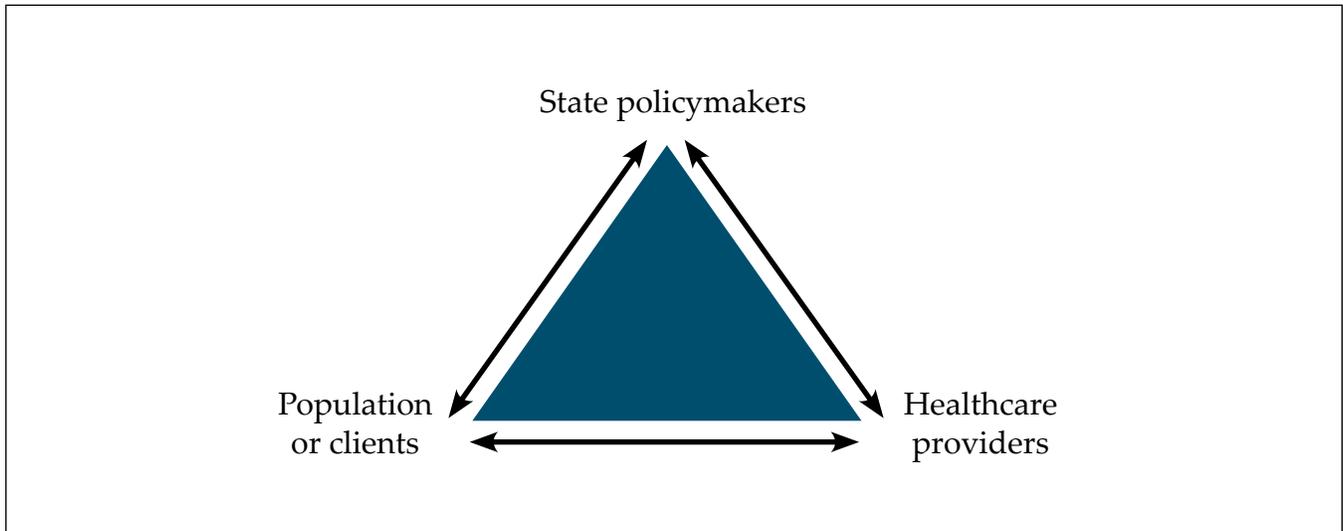
CHALLENGES FOR PROVIDING HEALTH SERVICES

The model for provision of health services in developing countries comes from the World Bank *World Development Report* of 2004, which

shows a short path and a long path to development (see Figure 2). There are three key actors: the state’s policymakers, the health service providers, and the population or clients. The population or clients are both the recipients of services from the providers and the constituents of the government policymakers. The policymakers establish the outline of the structure for the health sector and will then either provide the services directly to the population or have a mix of public and private providers deliver the services. Whatever mechanism is chosen, the state’s stewardship role requires that it serve as overseer and regulator of the health sector, even if the public sector provides all health services. The direct path for service delivery, shown on the bottom of the drawing, is when clients demand services directly from the providers. The “long route” is when the population influences policymakers in government and holds them accountable for influencing the providers. This influence is brought to bear on the type and quantity of services as well as on the quality of those services and the way compliance with standards is monitored.

The DAC model for analysis of service delivery is useful for analysis; for example, when one or more of the linkages shown in Figure 2 is broken or not functioning properly, there is a problem in service delivery. If the state is not operating well, as we could expect in deteriorating states, states in the early stages of post-conflict situations, or collapsed states, policymakers will not be accountable to the population. In such instances, there will be few control mechanisms, including less control of health care providers than usual. This means that health providers may not be responsive to clients.

Figure 2. Actors in the Delivery of Health Services Model



Source: *World Development Report*, World Bank, 2004.

Because many health care providers are leading professionals in a society, they often have an opportunity to emigrate or make a living by other means during times of deterioration and conflict. Hence, in fragile states, the number of health care providers is frequently insufficient to provide an adequate quantity of health services. Thus the linkages between clients and providers may be broken because of the lack of providers even when other linkages have not been disrupted.

The DAC indicates that the amount of financial resources for provision of services is not as critical as the way the health service delivery system is organized, that is, the way in which the triad of relationships is structured. In fragile states, whether services are best provided by the government, the private sector, contracting for services, creation of a competitive market, or a combination thereof will vary according to the circumstances. Not surprisingly, the DAC group concluded that one type of service delivery model will not be appropriate for all fragile states. Whether service provision is organized

in a centralized or a decentralized manner will also affect the effectiveness of service delivery. The state will play a role in policymaking, even if only by defaulting and allowing the sector to operate in a totally uncontrolled and unregulated manner.

Another key issue related to fragility is the state's ineffectiveness in providing basic services to the population. Humanitarian crises often emerge due to this breakdown of curative services as well as the public health services critical for reducing morbidity and mortality. This breakdown in service provision is not always due solely to recent armed conflict; it can occur in deteriorating states as well as collapsed states. The situation and state of fragility in each country will have a tremendous bearing on the type of intervention required for basic health service provision.

Humanitarian crises require immediate action and intervention. The international community will not feel it can stand by and await the longer-term process of restoring security, re-

forming systems, and building capacity before services can be provided. In these situations, the lack of credible government provision of health services means that international bilateral or multilateral agencies will step in to establish the necessary policies and identify what services will be provided, at what level, and for what period. Such intervention may also be the case even in countries that have not had armed conflict but where the state has collapsed. The agencies wish to quickly engage the government to assume its essential functions for the health system.

CHALLENGES FOR STRUCTURING THE HEALTH SYSTEM

Four principal questions must be asked about service provision, whether with the short-term goal of responding to a humanitarian crisis or the long-term objective of re-establishing or developing a functional and effective health system:

- What health services are to be delivered?
- How are the health services to be organized and produced?
- Who will receive the services?
- Who will pay for the services and how will providers be paid?

These questions deal with the allocation, means of production, distribution, and financing of services. The four questions must be answered by every developing country to determine how to structure its health service delivery system. However, it is even more critical to answer all these questions in a fragile state situation to make sure that all elements are considered in establishing health services.

The answers are critical because they will determine whether the health system will be focused on curative or public health and preventive services; whether there is equity in the health system; whether services reach rural areas or the urban population is the primary focus of the health system; and who will bear the cost of the health system as well as the payment incentives that influence how providers deliver services. So these questions have significant and long-term implications for a country's health system.

The answers to these questions will not be static. Over time the responses may change as one shifts from dealing with the humanitarian crisis to developing a functioning and sustainable health system. Table 1 illustrates the variety of responses that one might consider for providing services in fragile states.

Summary: Key Issues in Structuring the Health System of a Fragile State

- **Allocation:** What health services are to be delivered?
- **Production:** How are the health services to be organized and produced?
- **Distribution:** Who will receive the services?
- **Financing:** Who will pay for the services and how will providers be paid?

Table 1. Summary of Health Service Provision Options by Humanitarian Crisis and Type of Fragile State

	<i>Humanitarian Crisis</i>		<i>Type of Fragile State</i>	
	<i>Declining/ Deteriorating</i>	<i>Collapsed/Arrested Development</i>	<i>Post-conflict/Recovering</i>	
Allocation: Services to be provided	<ul style="list-style-type: none"> Emergency response: epidemic control, essential public health services (e.g., immunization, malnutrition, MCH) 	<ul style="list-style-type: none"> Basic health services 	<ul style="list-style-type: none"> Basic health services 	<ul style="list-style-type: none"> Start with basic services Expand to hospital-level care
Production: Organization of services	International agencies and donors provide services	International agencies, non-state providers (NSPs), and NGOs	International agencies, NSPs, and NGOs	Government starts determining appropriate public-private mix
Distribution: Recipients of services	Vulnerable populations	Attempt to provide services widely	Initially the most vulnerable	Attempt to expand access and ensure equity
Financing: Payment for services				
<ul style="list-style-type: none"> Who pays 	International community	International community	International community	<ul style="list-style-type: none"> Donors Trust funds Global partnerships Fees (consideration given to sustainability)
<ul style="list-style-type: none"> How providers are paid 	<ul style="list-style-type: none"> Contracting for services Fee for service in private sector 	<ul style="list-style-type: none"> Contracting for services 	<ul style="list-style-type: none"> Contracting for services Government Private sector 	

CHALLENGES FOR PRIORITIZING THE HEALTH SERVICES TO BE PROVIDED

The health problems facing a fragile state, during a humanitarian crisis or as it seeks to move beyond its fragile status, are enormous in light of the magnitude of the health problems it faces. The challenge in any country with scarce resources is to focus on those interventions that will positively impact public health, in other words, those that will have positive results on the health of the entire population. Many interventions are proposed to fragile states to deal with the enormity of the health problems they face. At times, interventions are proposed because they are part of the routine arsenal of an aid agency. Sometimes they are the agency's favored approach of the moment, or it may transplant a model deemed successful in another country to a fragile state without considering the local context.

Hence, countries must establish some criteria for selecting among the various interventions and health services that are to be provided to the population. These criteria will help (1) establish priorities among competing demands, (2) establish criteria so that the same factors are used in making choices among alternatives, (3) ensure that policy decisions are consistent with national health objectives, and (4) make sure priorities are maintained.

The primary concern in determining priorities and the content of health programs is whether the services proposed will address major health problems. In deciding whether a public health intervention will succeed in having a positive impact on the health status of a population, governments and donors can apply five criteria: impact, effectiveness, scaling up, sustainability, and equity.

The Ministry of Public Health of Afghanistan recognized that donors or others in the Afghan health system often exert pressure to introduce various interventions and make them a priority. While well intended, such interventions may be costly and benefit only a small number of people. To guarantee a balanced perspective as requests are made of the MOPH to introduce new services throughout the country, the MOPH developed a set of criteria that it termed "The Public Health-Based Decision Framework." It was the basis for developing the country's Basic Package of Health Services (BPHS) in 2003, which established the government's priorities for addressing the dire health situation after the fall of the Taliban. This Public Health-Based Decision Framework continues to serve as a basis for making decisions about expanding the BPHS. The framework consists of five basic questions:

Providing a Basic Package of Health Services: Democratic Republic of the Congo

"One of the most important of these was the development of a Basic Package of Health Services (BPHS) that is intended not only to guide the activities of peripheral health facilities, managed by the Bureau Central de la Zone de Santé, and encompassing the range of facilities from the Hôpital Général de Référence (district-level hospital) to the poste de santé, but also to provide guidance to the donors as to what kinds of health programs they should support. The development of the BPHS was a political, as well as a technical, event in that it brought together, for first time since hostilities broke out, health authorities working under the jurisdiction of all of the important armed political factions at the time. This is important in that it suggests that at least a small role for the health sector in forging and possibly in maintaining the fragile peace is possible." (Waldman 2006, p. 23)

- **Impact:** Do the services proposed have an impact on the major health problems?
- **Effectiveness:** Does the intervention have proven effectiveness?
- **Scaling up:** Can this intervention be implemented on a large (national) scale?
- **Equity:** Will access to and benefits from the intervention be fair to all?
- **Sustainability:** Is the intervention affordable in the long term?

CHALLENGES FOR FINANCING HEALTH SERVICES

Donors and national governments must determine how to provide health services, but while protecting the health of citizens is a priority for virtually all fragile states, efforts to move toward this goal draw on common and limited resources from donors and are affected by the rules influencing donor activities. Commitment of resources and priorities for health must be balanced with other, equally compelling national priorities in the overall context of fragile state development. The challenge is to answer these questions in the broader context, in which the fragile state is dealing with the goals of meeting immediate basic needs, and dealing with security, reform, and capacity building.

Some of the options for provision of health services (apart from the government acting as a health service provider) are discussed below. Table 2 summarizes some of the primary advantages and disadvantages of various service provision methods.

General budget support. Donors may provide general budgetary support to the government. Donors may wish to do this to show

support for the government and its ability to be accountable for donor funds. The use of this mechanism, however, is often difficult in fragile states because the systems and means for accountability are usually insufficient for donors to be willing to provide general budget support. Donors may wish to earmark such support for the health sector to try to maximize the impact of their resources on delivery of health services. Donors may do this either by supporting the budget or providing the finances for governments to contract with NGOs to provide the services. Donors have been most willing to use this mechanism when there is a trust fund established that is operated jointly by a multilateral agency and the government's finance ministry.

Sector-wide approaches. Sector-wide approaches (SWAs) are a mechanism for harmonizing donors while pursuing alignment with the government's priorities. These approaches are meant to facilitate strong government ownership and leadership of the health sector by transferring decision-making to the developing country. While SWAs are not a service delivery mechanism, as a means for coordinating donors they may make it possible to extend health service delivery to large parts of the country. They may also be used for filling gaps through specific disease or immunization programs, as in East Timor. The case for using SWAs in fragile states is stronger because of the urgent need for action in which donor resources are coordinated rather than duplicative or competing.

One difficulty in using SWAs in fragile states can be the weakness of the government in managing such coordination. There are often government capacity issues with SWAs. It may be difficult to coordinate the donors participating in the SWAp as well.

The Challenge of Capacity for Directing SWAp: Papua New Guinea

“Since 1999, the government, with AusAID, ADB and NZAID support, has been pursuing a sector-wide approach (SWAp) with the formation of the Health Sector Improvement Program to provide a mechanism for pooled funding. AusAID has supported this process through a phase-out of project aid for health (most projects ending in 2004), channelling recent support through a Health Sector Support Program and establishing, in 2005, a Capacity Building Support Centre. Government has lacked capacity to lead the SWAp process, especially at provincial levels in the decentralised system, with interruptions to flow of funds and other implementation. Despite this, the SWAp in PNG offers an excellent opportunity for joint funding, donor coordination, and facilitation of a partnership approach. However not all donors have participated, or participated fully, and tensions between major donors are an important constraint to harmonisation.” (Malau 2005, p. 5)

Contracting. In developing countries and a number of fragile states, contracting with international and national NGOs is being used as a mechanism for providing health services to large and targeted areas of the population. This approach is having a positive effect in extend-

ing access to people. Cambodia, Afghanistan, and Congo have used variations of contracts with NGOs. In Afghanistan, the use of contracting by three major donors has increased access to basic health services from 5% in 2002 to an estimated 77% in 2006.

Providing Services through NGOs in Fragile States: Nepal, Guatemala, and Côte d'Ivoire

“NGOs, local and international, are important partners and complement the services provided by or through state structures in many fragile states. They are, however, no cure-all. In some cases, especially where they lack legitimacy, they are not sufficiently trusted by the population or political forces (Maoists in Nepal). Accordingly, they do not automatically enable a more direct access to the most needy in society.” (BMZ/GTZ 2006, p. 4)

The advantage of contracting is expanding health services quickly. The disadvantage is that it may bypass government mechanisms as donors provide contracts or grants directly to NGOs. Without government oversight, there can be a backlash against NGOs.

Global health partnerships. A more recent development has been global health partnerships (GHPs). The McKinsey study (2006) discusses five advantages of GHPs, which:

- avoid duplication of investments and activities;

- produce economies of scale;
- pool resources to enable higher-risk activities than any partner would undertake alone;
- share knowledge and resources to improve effectiveness;
- create momentum and attract funding by building a common “brand” that gains legitimacy and support.

Global health partnerships are providing an increasing amount of critical resources to de-

veloping countries to address specific diseases or category problems. GHPs have not been involved to a large extent in humanitarian relief activities but have focused more on vertical interventions for specific diseases. The resources of GHPs can be helpful to fragile states for “plugging gaps,” such as restarting a national tuberculosis program with a grant from the Global Fund against AIDS, Tuberculosis and Malaria. Often GHPs focus on public health interventions. Or there may be other specific issues related to a poorly functioning health system that can be addressed, or a pilot can be started with funding from a foundation.

GHPs can help countries, and especially fragile states, address major public health problems, but the challenge is to make sure they contrib-

ute to the overall development of the health system. GHPs are now examining their role with regard to fragile states. A potential disadvantage is that their programs may not be properly integrated into the provision of basic health services in a fragile state. There may also be questions about sustainability. One of the emerging concerns of GHPs is the need to begin focusing on health system development if they are to improve the impact of their programs.

The options discussed above are not mutually exclusive. Donors may seek to use several of these options in combination. Table 2 summarizes the advantages and disadvantages of these various donor options for financing health services.

Table 2. Options for Donor Financing of Health Services in Fragile States: Advantages and Disadvantages

Advantages

Disadvantages

General budget support	<ul style="list-style-type: none"> ■ Donor alignment with gov't priorities ■ Enhances donor-gov't accountability ■ Supports gov't ■ Aligns support with gov't priorities 	<ul style="list-style-type: none"> ■ Potential for money being pulled away from health services to other gov't services ■ Not targeted to those in greatest need ■ Dilutes donor attribution ■ Impact on improving health is weakened
SWAPs: Pooled donor funding	<ul style="list-style-type: none"> ■ Donor alignment with gov't priorities ■ Harmonization among donors ■ Enhances donor-gov't accountability ■ Efficiencies—reduces transaction costs ■ Aligns budgeting with priorities 	<ul style="list-style-type: none"> ■ Lack of gov't capacity to coordinate ■ Lost opportunities for broader impact on gov't financial, logistics, and service delivery systems ■ Dilutes donor attribution ■ Difficulty in getting all major donors to participate
Contracting with NGOs for service delivery	<ul style="list-style-type: none"> ■ Services extended quickly ■ Promotes gov't role of steward, overseer, and regulator of health sector ■ Promotes a basic package of health services for delivery throughout the country ■ May be more cost efficient than gov't provision of health services ■ Leverage for monitoring NGOs' performance in extending access and providing quality care 	<ul style="list-style-type: none"> ■ Potential for donors to bypass gov't in contracting with NGOs since contracting requires gov't capacities and systems to adequately manage contractors ■ Dependent upon NGOs being able to scale up their service provision capacity quickly ■ Cost and sustainability questions arise when main contractors are international NGOs or local private providers ■ NGOs' contractual relationship with donor or gov't may compromise their perceived "honest broker" role ■ Issue of sustainability for the long term
Global health partnerships	<ul style="list-style-type: none"> ■ Widens coverage, especially of the poor, for provision of certain disease-specific services or prevention ■ Can fill gaps of service provision ■ Addresses imbalances in equity and access ■ Standardized approaches help promote faster implementation 	<ul style="list-style-type: none"> ■ System, management, and sustainability issues similar to contracting with NGOs (limited capacity for absorbing resources) ■ Requires strong leadership and management capacity ■ Potential parallel or duplicative mechanisms ■ Disease-specific interventions may create nonintegrated services ■ May not support capacity building throughout the health system ■ Requires a coordination mechanism within Ministry of Health ■ Global mechanisms may not be flexible enough for fragile states

SECTION V: Essential Principles for Health Sector Interventions in Fragile States

This paper has extracted some crucial issues for fragile states and discussed how those issues affect the introduction or restoration of health service. The objective of this information sharing by the Working Group on Health Service Delivery in Fragile States¹ and this analysis has not been simply to learn what works, but rather to try to understand the conditions that make certain interventions effective in some fragile states but not in others. This final section synthesizes some of the major elements that have been recognized. The first elements covered are not specific to the health sector; elements related to health follow.

PRECURSORS TO ACTION

Recognize that each fragile state is unique.

No one disputes that each fragile state is different, but the Working Group has attempted to see what may be learned from the experiences of different states. Interventions and policies that have worked elsewhere cannot necessarily be applied in new situations. Yet, although all fragile states start from a unique strategic position, they all face pressure to address the problems of illness and support the provision of health services, regardless of the existing structure and organization of health services. The ultimate objective is to improve health as part of the bigger picture, which includes establishing a stable state that not only enjoys legitimacy but is also effective in delivering health services to the population, including achieving the critical goals of access, quality of care, and client protection.

¹ This working group is part of the Fragile States Group of the Development Assistance Committee of the Organisation for Economic Co-operation and Development, an international organization based in Paris.

Use typologies as a starting point for analysis.

The typologies developed to describe the characteristics of fragile states are useful in attempting to take complexity and simplify it to increase understanding of the issues facing these states and how to respond effectively, and, ultimately, to determine what can be done to prevent states from becoming fragile. There are two key points to remember in describing fragile states. First, rather than apply a one-dimensional definition of fragility, it is useful to consider states as occupying points along a continuum for each element of fragility. Second, in keeping with the idea of a continuum, states may move in and out of fragility. It is important to remember that once states appear to be performing satisfactorily, they may still be in a tenuous position from which they may slip back into fragility.

Consider health in the context of the bigger picture.

Donors and the international community seek to address the legitimacy and effectiveness of government in fragile states. Although health issues are central to this working group, there is a broader issue of re-establishing the rule of law in fragile states. This re-establishment must be promoted to help rebuild public confidence (legitimacy) and empower the state (effectiveness).

Additionally, health care is not the only basic need that must be met. Other needs, including food, water, shelter, sanitation, and security, must also be addressed, and they will compete for donor resources and attention. Those who attempt to address the health needs of fragile states must remember that other basic needs are important, too.

PROMOTING LEGITIMACY

Demonstrate progress and communicate success. States seeking to re-establish legitimacy must take some initial steps to demonstrate that they are making attempts to address the health needs of the population. Clear progress must be made that is visible and demonstrates positive change to the public.

Health care has a vital role to play in demonstrating progress and communicating that progress to the public. Confidence grows as promises are fulfilled and services are extended to more locales as security is improved, resources become available, and the capacity to operate health facilities is expanded. Thus health care is an important element that states can use to show that they can be effective in delivering services and to establish their legitimacy (a “peace dividend” to the public).

PHASING IN INTERVENTIONS

Make saving lives a first priority. Often fragile states face a humanitarian crisis. When that occurs, donors’ foremost priority must be to provide interventions that will save lives. Interventions must be sequenced to begin by addressing the most easily preventable deaths and diseases. Immunizations must be provided. There must be control of diseases and promotion of public health services. After the situation stabilizes, donors may work with the state to determine the basic health services that must be provided.

After the immediate response to humanitarian crises comes the need to transition to develop-

ment actions. Because health is part of a larger picture, donor actions with the Ministry of Health should not make drastic changes with political implications. Instead, donors should restore, repair, and build on the health system elements that worked well prior to fragility. In post-conflict countries it is often the case that the humanitarian crisis persists and there is not a clean transition from emergency to development. Rather relief and development need to take place at the same time.

As humanitarian assistance wanes, there may be a gap in services if development did not begin during the crisis stage. Therefore, donors must develop flexible aid instruments that can deal with humanitarian crisis and development simultaneously. Although this need for change is well known, it has had little effect on donors’ practices.

A humanitarian crisis requires concerted action for about 6 months to save lives. In the next 12 months, governments and donors can support a number of activities to move a country from a crisis to longer-term positive development. When there has been conflict, some interventions seek to bolster initiatives for peace as well as provide health care to the most vulnerable, but the basic need is to address current problems. Beyond 18 months, governments need to develop a strategy to select the interventions that will help the most people in moving the fragile state toward transitional development. The summary box “Sequencing of Health Sector Interventions in Fragile States” provides specific interventions and timing for donors and host governments to consider.

Summary: Sequencing of Health Sector Interventions in Fragile States

Urgent Health Needs (1–6 months)

- immunizations
- essential drugs and vaccines
- disease prevention, care, and treatment
- humanitarian assistance and care for internally displaced persons and refugees

Quick-Impact and Medium-Term Responses (6–18 months)

- **Pharmaceutical management:** Improve drug supply.
- **Expansion of services:** Provide basic health services through NGOs.
- **Maintenance of existing services:** Preserve basic health services and extend them to cover services required by the referral system.
- **Creation of infrastructure:** Construct and rehabilitate strategic health facilities, especially for needy populations.
- **Promotion of community participation:** Build capacity to respond to specific health concerns by promoting community involvement in identifying health needs and approaches to addressing those needs.
- **Development of health sector policy and regulation:** Begin reforms necessary by starting with the basic policy and regulatory role of the Ministry of Health.

Longer-Term Development Responses (18 months–5 years)

- **Access and equity:** Increase access to basic health services.
- **Involvement of civil society:** Engage civil society to meet the health needs of the population, especially for specific diseases, such as HIV & AIDS.
- **Policy and regulation:** Provide technical assistance to the Ministry of Health to build its capacity and develop a policy framework for the health sector.
- **Planning capabilities:** Develop the government's capacity to analyze information, make long-term plans, and develop intermediate plans of action for implementation.
- **Capacity development:** Develop human resources for health by working with training institutions and on testing and certification systems.

- **Community participation:** Develop hospital boards and local health committees to empower local communities.
- **Disease surveillance:** Help develop sentinel surveillance and response systems to monitor diseases.
- **Prevention and control of diseases:** Address the problems of TB, HIV & AIDS, and malaria.
- **Private-sector capacity:** Develop the capacity of private-sector providers to meet health service needs while simultaneously strengthening the government's capacity to regulate the private sector.
- **Sustainability:** Address issues of long-term sustainability of health services.

Coordinate with other donors. Initially, the government will be hard pressed to exert much authority and will have little coordination capacity. Therefore, it is important that the donors themselves coordinate with each other as well as with the government. During a crisis, harmonization is easier, but as the crisis dissipates, it becomes increasingly challenging for donors to harmonize their work. Donors are hampered because they cannot change the systems of their own governments if that would be best in a particular situation. These realities mean that the government and donors should develop joint mechanisms that each donor must adhere to in order to meet its own government's requirements *and* align with the host government's priorities. For instance, if donors are making grants to NGOs to provide health services, it may be

unrealistic to expect that all such donor resources will be placed in a common basket or that the government can demonstrate the proper level of accountability to give the NGOs the funds directly. Hence each donor will be providing grants under its own system requirements.

Other elements can be common across all donors, however. For instance, a fragile state could have common procedures among all donors for establishing priorities and monitoring grants, but the government selects grantees separately with each donor to meet the donor's particular requirements. This is not an ideal, but it is a possible practical and creative solution to meet individual donors' requirements while developing the government's capacity for handling grants on its own.

National Capacity Is Required for Coordination of Donors: Lao People's Democratic Republic

"Future development assistance in the medium term could reasonably include project aid and support to national technical programs, such as EPI. However there remains a need to support national policy and stewardship functions, and build central capacity for coordination. There seems [to be] insufficient government capacity to lead a sector-wide approach program, so alternative means to provide program style support to this level such as special funding facilities would be required." (Toole 2005, p. 7)

PRIORITY ACTIONS

Place experienced technical experts on the ground for extended periods. Several recent publications have noted that fragile states need technical experts who have a wide range of experience and multiple skills. In addition to having experienced staff, these states need technical experts who will be present over an extended period rather than simply make periodic visits. Periodic short visits by technical advisors are not sufficient to develop the capacity required by government to assume its functions of oversight and stewardship of the health sector. Long-term, experienced staff can provide the needed mentoring of senior staff in the state's Ministry of Health.

Help establish the role of government to manage the health sector. The government

needs to work with other national and local authorities as well as with NGOs in re-establishing health services. It must clearly assume the role of steward rather than primary deliverer of health services. As steward, the government is responsible for preventing fragmentation of services and duplication, which would waste scarce resources. Because there will be a proliferation of private-sector health services, the Ministry of Health must monitor and regulate all health services, not just those funded by the government or donors.

Practical planning includes short time horizons. The focus should be on achieving results that can be demonstrated and on collaboration between actors. Attempt to combine resources and use them to develop an entire menu of activities.

Importance of Continuity of Donor Advisors: Kyrgyz Republic

“Another aspect of the ‘human factor’ is the long periods of continuous input from certain outside advisors. For example several advisors with WHO, USAID, Swiss project and STLI have had connections with Kyrgyzstan of long durations of time, enabling informed and sustained technical input. . . . However future development assistance mechanisms, here and elsewhere, should, at the very least, remove hindrances to long-term commitments to health development activities. More, the international development community needs to find better ways to promote such durable and enduring investments of resources and people in health.” (Morgan 2005, p. 10)

Gather information. It is essential to understand the population's current health needs and nutritional status, the condition of the health infrastructure (human resources, facilities, equipment, and supplies), and the resources required for provision of basic services. Comprehensive surveys that take a long time to complete are not as useful as surveys with less detailed information that can be quickly provided to donors and policymakers.

Establish health sector priorities. Focus on priority health needs using a framework that balances addressing urgent needs with

longer-term health sector development and the achievement of national health objectives. Such a framework should clarify the interaction of targeted interventions, using criteria like those presented on p. 26: impact, effectiveness, scaling up, sustainability, and equity.

Pilot projects can be important means for validating radical changes in the health system prior to scaling up. Pilots are usually most appropriate in states that are in recovery, although in stagnated or collapsed states pilots can be carried out to see if innovations and sweeping changes are feasible.

Pilots as a Prelude to Scaling Up: Kyrgyz Republic

“In particular the pilot in Issyk-Kul oblast was important in demonstrating that MHIF [Mandatory Health Insurance Fund] payment mechanisms and primary care restructuring could work in practice. It was very rapidly scaled up by the government, with WB support, and integrated into the Manas strategy.” (Morgan 2005, p. 9)

Address health sector financing and sustainability issues. Donors and governments need to know what resources are required to provide basic health services. Obtaining this information may require costing the services that are planned. This estimation will be helpful not only for donors but also for re-establishing the recurrent budget for the health system. For instance, if required resource levels are unknown, it is difficult to obtain donor commitments for longer-term development of the health sector. In Afghanistan, the costing of the Basic Package of Health Services at US\$4.50 per capita facilitated the large commitments by the World Bank, USAID, and the European Commission to fund extension of the services to the population. From early 2002 to early 2006, the percentage of the population that has access to basic health services has increased from 5% to nearly 80%. The costs were found to be within the range of the estimate made in mid-2002: from \$4.38 to \$5.12 per capita for the provision of the basic package of services (Newbrander, Yoder, and Debevoise 2007).

Sustainability of health systems that are developed is important for governments to address as donors provide inputs. The provision of capital inputs must be weighed against the sustainability of such investments for the long term. While large capital investments may be a government responsibility, their attractiveness makes it difficult for a ministry to consider them objectively. Donors can assist with building the capacity of government to do long-term financial feasibility and sustainability analyses as part of due diligence in considering offers of aid. Sound financial management is needed to manage resources, qualify for international resources, and foster the confidence of the international community that resource inputs are not only targeted but also well spent and accounted for.

An additional concern of countries is the predictability of aid flows from donors. While donors have identified this problem, little has been done to address it.

Costing of Priorities: Lao People’s Democratic Republic

“The strategic framework for the health sector is coherent and prioritised. However, the strategies have not been translated into a budgeted work plan.” (Toole 2005, p. 6)

Develop human resources and capacity. The health of the health system depends on having an appropriate mix of health providers who are qualified and provide high-quality health services in an efficient manner. This is a long-term effort, but it requires starting to address the issue of human capacity soon after donors have begun to

intervene in the health system of a fragile state. In post-conflict or recovering states, because of the time lag between preservice training of health workers and the delivery of services by those workers, the state and donors need to begin addressing human resource development issues during the peak of the crisis.

Summary: Essential Principles for Health Sector Interventions in Fragile States

Precursors to Action

- Recognize that each fragile state is unique.
- Use typologies as a starting point for analysis.
- Consider health in the context of the bigger picture.

Promoting Legitimacy

- Demonstrate progress
- Communicate success.

Phasing In Interventions

- Make saving lives a first priority.
- Coordinate with other donors.

Priority Actions

- Place experienced technical experts on the ground for extended periods.
- Help establish the role of government to manage the health sector.
- Gather information.
- Establish health sector priorities.
- Address health sector financing and sustainability issues.
- Develop human resources and capacity.

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