HEALTH PROGRAMMING IN POST-CONFLICT FRAGILE STATES

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Abbreviations

BPHS	Basic Package of Health Services
DART	Disaster Assistance Response Team
DfID	Department for International Development
DRC	Democratic Republic of Congo
EC	European Community
EPI	expanded program of immunization
IMCI	integrated management of childhood illnesses
MDGs	Millennium Development Goals
NGO	nongovernmental organization
SWAp	sector-wide approach
USAID	United States Agency for International Development

Introduction

Over the past few years, a lot has been written about how to organize and implement the delivery of health services in countries emerging from conflict.[1] These countries are recognized as "fragile states." While several types of fragile states have been identified, and several typologies exist, the one being used for this series of papers classifies fragile states as post-conflict, early recovery, arrested development, or deteriorating governance. It is recognized by those most familiar with this area of work that these classifications are arbitrary, that they depend on what might be very different perceptions of many external observers, that a given country can fall into any one of these categories at different points in time, or that a single country, or even parts of a country, can be in different categories at the same time. When trying to address the needs of fragile states, donors may have different objectives, different kinds of programs may be more or less appropriate, and different lending instruments may be more or less efficient and effective. As of this writing, there are far are more questions than answers and far more theory than experience—a substantial area of research ought to be opened up because one thing on which everyone seems to agree is that finding better ways to help countries reach a level of stability from which both social and economic development can accelerate is in the best interests of the countries themselves, their neighbors, and the donors. After all, the underlying motivation for providing assistance to fragile states is often not humanitarian, but rather one of improving regional and even global security.

Because so much already exists, this paper will take the form of a shorter note, one that is intended to outline some more prominent issues that need to be considered by those involved in developing, financing, and implementing foreign assistance programs, especially by those posted in the field, who are often besieged by different, and sometimes contradictory, ideas emanating from their own or other donor headquarters. What these ideas have in common is that they frequently ignore the context in which they are supposed to be applied. This paper cannot supply that context. Although it draws on case studies that have been conducted in a number of post-conflict states, one lesson that has been learned many times is that every country is different. On the other hand, to say that health programming in the post-conflict environment is totally context-specific would be to deny the many common features that have been pointed out elsewhere.[2] In addition, because little has been written about it specifically, and because its preparation is being funded by the United States Agency for International Development (USAID), this paper tries to represent (without endorsing) how health programming might relate to USAID's Fragile States Strategy.

An Important Distinction

This paper is specifically <u>not</u> titled health care delivery in post-conflict states. It is not about the importance of delivering health care services or about how to tailor traditional health programs, as they exist in non-fragile states, to a different, arguably more complicated environment. Instead, this paper suggests that the principal causes of morbidity and mortality in post-conflict states specifically, and in fragile states more generally, may not be specific diseases that need to be controlled with programs such as

[1] A variety of descriptive and analytic papers addressing various themes related to fragile states can be found, for example, at www.usaid.gov, www.dfid.gov.uk, www.oecd.org, and www.hlfhealthmdgs.org.

[2] One of the better summaries of how to most effectively deliver health services in post-conflict environments is "Health Care Delivery in Post-Conflict States," by E. Pavignani.

the expanded program on immunization (EPI), integrated management of childhood illnesses (IMCI), or even HIV/AIDS, tuberculosis, or malaria control. In fact, the question of what is responsible for most morbidity and mortality in many countries can perhaps be better answered by terms like conflict, political instability, poor governance, abject poverty, and so on, than by one or more diseases. If this is so, then the important issue becomes not so much what health programs should be implemented and how, but rather how can health sector programs be designed and implemented in such a way that they contribute to identifying and resolving the political, social, and even economic drivers of fragility within a given country.

For example, a recent nationwide mortality survey conducted by the International Rescue Committee (Coghlan et al. 2006) in the Democratic Republic of Congo (DRC) revealed the following:

Table 1: Democratic Republic of Congo—Deaths per 10,000 per day

	Crude mortality rate (95% CI)	Under-5 mortality rate (95% CI)
Health zones reporting violence	3.0 (2.6–3.4)	6.4 (5.7–7.2)
Health zones not reporting violence	1.7 (1.5–1.9)	3.1 (2.7–3.5)

Source: Coghlan *et al.* 2006, 47.

The authors of this technically sound study summarized their findings by saying that "reductions in crude mortality are closely associated with reductions in violence and, by extension, improvements in security . . ." and they conclude that "these trends. . . provide compelling evidence that improvements in security represent perhaps the most effective means to reduce excess mortality." The implications of these data and the authors' comments are telling—if the principal objective is to improve the population's health, perhaps disease control programs as they are usually conceived should not be the health sector's highest priority, at least in a context where conflict is occurring or where the likelihood of a return to conflict is appreciable. Instead, programs that aim to bring about a lasting ceasefire or that contribute to the consolidation of an ongoing peace process are more important in the immediate, highly fragile, post-conflict setting. One should certainly not ignore the potential ability of disease control programs to make an important contribution in this regard, but they might need to be appropriately designed and implemented with non-disease control objectives in mind and their impact on non-disease parameters will need to be measured.

In sum, health programs may be important in the post-conflict setting not because they lower the burden of disease, but because they lower the level of tension within a society and reduce the high-risk conflict recidivism (Collier 2004).[3] If so, they can contribute to the creation of a more stable environment in which, at a somewhat later stage, disease control programs can be implemented more effectively and on a larger scale than what might be possible in the immediate post-conflict period.

[3] In this study, the author states that "around half of all civil wars are due to post-conflict relapses" and that "the risks of conflict relapse are very high during the first post-conflict decade – typically around 50%."

The Objectives

USAID's Fragile States Strategy seeks to reduce instability. It states "instability . . . is the product of ineffective and illegitimate governance." It stands to reason then that programming in accordance with the USAID strategy means designing, funding, and implementing programs that try to improve both the legitimacy (the perception that a government is fair and is working in the interests of a nation as a whole—it is a function of broad representation) and the effectiveness (the government's ability to discharge its core functions, including the delivery of socially-relevant goods and services) of government in countries emerging from conflict. Government as used here should have an asterisk; it is important, but not frequently emphasized, that there is a very big difference between government and governance. Although there are many different governance definitions, none is universally accepted. Governance basically has to do with steering a society toward the achievement of long-term objectives. For this, both government and civil society are required, at times one more than the other, but always in partnership. Governments may be legitimate (or not), but it is civil society that confers legitimacy (or not); governments can rule in a way that seems effective, but it is civil society's reaction to that rule that actually determines whether or not it is effective. Implementing USAID's Fragile States Strategy means dealing with both—there has been strong rhetoric from several of the major donors in the health sector, especially the U.S. and the World Bank, regarding the importance of state building, but not enough stress on the notion that state-building means strengthening both government and civil society (more on this later).

The notion of state building stands at the heart of the post-conflict health programming dilemma and deserves further discussion. Reading the literature, one finds two sets of objectives clearly enunciated for working in fragile states. Above, we saw that the U.S. has couched its aims in political terms. Traditionally, however, and for many donors still, development objectives have been humanitarian: poverty reduction, improved health and education indicators, and the like have been kept quite separate from the political encumbrances that so greatly affect the ability to achieve them. It is probably a good idea for all donors to embrace both types of objectives, recognizing that there is clearly potential conflict between the more or less political aspirations of the USAID fragile states strategy and the more or less humanitarian ones of other strategies. On the other hand, there is a potential complementarity as well. In any event, both objectives are important, and neither should be pursued to the exclusion of the other.

In summary, then, the USAID Fragile States Strategy has four priorities: enhance stability; improve security; encourage reform throughout areas of governance; and develop institutional capacity. The question to be asked (but not necessarily answered) in this paper is: what is health programming's role in addressing these priorities? The document cited mentions health only in regard to the last of these priorities and only in the context that stronger health systems might "reduce stress and vulnerability, especially among poorer populations." The implication is that health programming has much less to contribute to the three other priorities.

Strategic Considerations

But is this true? Or can health programming also enhance stability by focusing on sources of fragility, for example? One can imagine a scenario where fragility is a function of the marginalization of certain ethnic groups (or in the post-conflict scenario, where

violence has been due to the discontent of one or more marginalized segments of the national population). Increasing social services to these groups, especially in the health and education sectors, might make a substantial contribution to securing the peace and helping a country to get back on the road to recovery and development. The barring of the Kosovar (Albanian) population from accessing public health services in Serbia, for example, has frequently been cited as an important factor leading to war in the Balkans. The acceptance of Hutu nurses back into Tutsi-run government services in Rwanda in 1996 was seen as an important stabilizing factor (although improved health services in this instance may have been of secondary importance to jobs creation).

A strategic tool commonly suggested to shore up a fragile peace is reinforcement of the so-called peace dividend—short-term, high-impact activities that, most agree, should be linked to long-term structural reform, as the Fragile States Strategy puts it. There are a number of specific health sector interventions that could make excellent, highly visible, greatly appreciated contributions to the peace dividend. Most commonly used is the childhood vaccination program—usually in the form of mass polio and/or measles vaccination, sometimes combined with the distribution of vitamin A capsules. The publicity surrounding these events, the gathering of large crowds in a single place, and the ability for local politicians to associate themselves with a combined government/UN activity are all potentially effective ways of highlighting the good social intentions of a new government and conferring upon it at least a temporary legitimacy. Of course, it would be best to determine the potential impact of this kind of activity prior to its implementation. From the population's viewpoint, childhood vaccination might not be an immediate priority—newly at peace, having been cut off from health services for months or years, a population might give much higher priority to the reconstruction or rehabilitation of health facilities and their stocking with useful drugs and supplies. Only talking to representatives of the population will help determine what the most important and most useful initial interventions might be, and local, not international, priorities should be respected.

The need to realize the peace dividend is one way in which the post-conflict setting is clearly different from the other types of fragile states. However, there is considerable overlap between the types of fragile states, and especially between the post-conflict and early recovery categories. There is at least one consideration that might serve to distinguish them; although establishing both legitimacy and effectiveness are clearly important, it may be more important to establish legitimacy first and leave effectiveness for later, if one has to choose between the two. In a very real sense, legitimacy and effectiveness, the proposed determinants of stability, create a dynamic tension. The more legitimate governance is, for example, the greater the representation, the more difficult the decision-making process becomes, both in terms of setting health sector policies and in implementing those policies in the form of effective programs. For this reason and others, they can and perhaps should be considered separately. In the example given above, the health facility itself and the drugs and supplies that are in them (accompanied by a health worker of some qualifications), may be more important demonstrations of government willingness and capacity (and confer greater legitimacy) than the presence of a highly trained, appropriately qualified health worker (which would be more of an indicator of effectiveness). To increase legitimacy by showing buildings and commodities may not have the beneficial impact on the population's health status that one might want, but the political impact of the simple provision of services, regardless of quality, might be very important in the longer-term and, as mentioned

above, might help considerably to pave the way for the accelerated provision of higher-quality services later on.
In terms of linking quick impact projects to longer-term goals, post-conflict health authorities in many countries (Afghanistan, Democratic Republic of Congo, East Timor, Liberia, Somalia, and so on) have found it useful to develop a Basic Package of Health Services (BPHS) in the early stages of health system reconstruction. The hope is that similar appropriate services will become available throughout the country; everyone will know exactly what to expect and will know exactly what is and what is not being delivered. In DRC, notably, the BPHS was developed by health authorities from throughout the country at a meeting organized by the World Health Organization and UNICEF in Nairobi well before the signing of the current Peace Accords. Historically, the DRC health system has had the strongest elements of governance and, even in the wake of frank conflict in the eastern part of the country that undermined both the central government's legitimacy and effectiveness, enough important elements of the health system, especially in the private sector, have endured to make it possible this sector to recover more quickly than others. If this is the case, the health sector could become a quite important and visible part of the rehabilitation process, assuming that the peace holds.

The Equity Issue

Linked to the BPHS, which is intended to be implemented throughout a country and up to the health system's most peripheral levels, is the frequently heard call for equity in post-conflict health system reconstruction (see Pavignani [2005], for example). Equity is a crucial characteristic, albeit one that is often not achieved, of health systems that work in accordance with humanitarian principles. Racial, socio-economic, and ethnic health disparities caused by the grossly unfair distribution of health services are the hallmark of many developing (and of most developed) countries. When it comes to the provision of social services, the lack of equity is deplorable. However, if a main objective of health system reconstruction is not only to achieve improved health status of the population in the short term, but also to contribute maximally to the consolidation of a fragile peace process, we might look at things differently. One could imagine, for example, a scenario where the greatest risk of recidivism of armed conflict is in geographic zones of a country that benefited, before and during the conflict, from health service delivery to a greater extent than areas that are farther from the war. Stabilization of a shaky truce might depend to the degree on which people in such a high-risk area perceive that their needs are being addressed. If limited resources are available, "new" government authorities might decide to give the "haves" more, to be able to provide services more equitably in the future, rather than to risk a return to violence and have no one get anything. This is the case, grossly described, of South Sudan, where the potentially volatile transitional areas, deemed to be at greatest risk, have benefited from some service provision (though little) because of the presence of northern Sudanese authorities. In implementing its Fragile States Strategy, USAID has decided to move its health program from the poor, very disadvantaged southern and western parts of South Sudan to the transitional areas, possibly contributing to greater inequity, or at least delaying more equitable processes, but possibly contributing as well, to increasing the probability of a lasting peace. Which is more important in the long run?[4]

[4] It must be said here that the way in which USAID went about making and implementing its programming decision can be, and has been, harshly criticized. There seems to have clearly been inadequate consultation with government authorities and with the other donors. On the other hand, according to at least one source,

At one point or another in this paper, the primordial importance of measurement will have to be mentioned. As the adage goes "what gets measured get done." Developing performance indicators is both a science and an art, but in all cases the presumption is that one knows what one wants to achieve. Again, donors, government, and civil society need to get together to decide on a clear and actionable monitoring agenda, one that might include elements of peace preservation, health system strengthening, and health status improvement. In any case, clear and measurable indicators of progress should be developed and universally adopted. Partnerships, such as the one described below in Afghanistan, are useful in this process. In Afghanistan, no indicators of lowered fragility were included in the health programs, but one scheme, implemented by the Ministry of Health with World Bank funding, did provide for an independent quantifiable evaluation of progress toward pre-determined health indicators.

All Fragile States Are Not Equal

As mentioned above, context is very important, but should not be allowed to become all-important. DRC and South Sudan are both relatively easy to place in the post-conflict category, but there are glaring differences. The peace accord currently being implemented in DRC has established a transitional government, with elections scheduled to take place in the summer of 2006 to determine which among the previously warring factions will rule over a well-established and long-recognized territory. South Sudan, on the other hand, is essentially a new political entity with a government, one that has already been accorded a large degree of legitimacy by its population, struggling for administrative and economic control, at least until a referendum to be held in a few years can (or might not) establish it as a separate country. In both, temporary power-sharing and wealth-sharing arrangements have been worked out. In both, the long-term prospects for peace, possibly prosperity (both are natural resource-rich), and rapid development depend to a large extent on how the losers of the upcoming elections will react.

One area where DRC and South Sudan are incredibly different is in the health sector. DRC has a legacy of reasonably effective primary health care—in the 1980s its health system was among the most effective in sub-Saharan Africa. There is much to be gained from an analysis of how health services were structured and delivered prior to the conflict period and much information to be derived from the many health care policy makers and providers, in both the public and private sectors, that have continued to struggle to provide services through the difficult times.

On the other hand, South Sudan has never had a functioning health system. At best, services were delivered in a makeshift fashion, with emergency funding by nongovernmental organizations (NGOs), churches, and a small number of "trained" government workers. There is no formal health system, no good practices to recapture (but no bad ones to get rid of), and no existing or prior policy framework. Stating things this categorically is, of course, an exaggeration, but it is essentially the case.

The point here is that there are obviously both opportunities and challenges to the reconstruction and rehabilitation of a health system in a post-conflict state, and these

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high-ranking political authorities in the new South Sudan government agreed with this shift in resources, although health officials and other health sector actors may not have.

depend to a large extent on what existed previously. It should hardly ever be necessary to start from scratch (although South Sudan may be a notable exception), as many building blocks usually exist. But there are many elements, especially in the management areas of primary health care systems in all developing countries that could benefit from serious review and reform. Pavignani makes both points strongly and lists a set of problems and opportunities that need not all be reviewed here.

Challenges for the Donors

Solving these problems and realizing these opportunities will be challenging whatever the prevailing context, but one prominent problem remains in all post-conflict settings in which donors are prepared to make substantial investments that is largely of their own (that is, the donors') creation. This is the divide that has grown between the relief and the development sides of donor agencies. Why this rift developed can be explained briefly; there is the need in emergencies to have different mechanisms of spending money (quickly, and with less accountability); there is the need to provide funding directly to NGOs and other private sector entities as conflict usually, but not always, means the total breakdown of a state's ability to perform any of its functions, including ensuring the delivery of social services; and there is the pure and simple focus on meeting humanitarian needs when people have no place to turn. Nevertheless, existing "handoff" systems, especially those of the larger donors, are clearly deficient. At the least, embedding a few post-conflict and early recovery programming specialists into emergency relief donor teams, like the USAID Disaster Assistance Response Teams (DARTs), seems appropriate. Curiously, relief-funding levels are frequently higher than those for development (at least this seems to be the case for per capita levels of spending in the health sector); people seem to be more generous when there is an immediate rather than a long-term need. A drop in post-conflict health sector funding can obviously work against the achievement of a peace dividend, and this possibility needs to be guarded against by those who know best how to make the financial transition successfully.

A second anomaly has to do with the design of the health programs that come online in the post-conflict period. These tend to look in every way like those that might be implemented in countries that are not emerging from recent conflict.

As mentioned above, the focus has been on how to implement the same programs in different circumstances, rather than to look at how the circumstances might determine the nature and design of the programs. Vaccinating 80 percent of children is one thing, but achieving high vaccination levels in a way that explicitly enhances the legitimacy (first) and effectiveness (later) of government may mean settling for lower levels of achievement, at least in some areas, paying greater attention to ensuring involvement of diverse elements of civil society, establishing routine vaccination at local health clinics, and so forth. Of course, it may also be the case, but hopefully not, that vaccination programs are not as early a priority as they currently are. How to make health system rehabilitation contribute to the attainment of political objectives is challenging and context-specific. Clearly, though, implanting programs designed for very different settings is likely to be problematic, and donors need to keep their objectives clearly in mind.

Donors invest in different ways, but in the post-conflict period, where the risk of recidivism of conflict and therefore the loss of that investment is great, it is

understandable that donors would seek to hedge their bets. Leader and Colenso (2005) review a range of donor instruments in their working paper for DfID. Some are less suited to post-conflict fragile states, such as sector-wide approaches (SWAps), where donor funds are mingled and, therefore, more difficult to account for. Others, such as multi-donor trust funds, have been used in settings as diverse as East Timor and South Sudan (just beginning). In general, there is rarely agreement on what form of lending or granting instrument would be best or, if there is agreement, there are domestic obstacles that prevent all donors from participating in a single funding scheme. A typical range of donor mechanisms is found in the DRC health sector; these are: direct payments to the government (African Development Bank); disbursements to the government through a fiduciary agent and a state-related, but parallel, management unit (World Bank); state avoidance—direct contract between the donor and private contractors, with some participation of the state in program design (USAID), and several steps between. Although this may not be the best of all possible situations, it is not unworkable and, for better or for worse, it seems inevitable. What is important is the frank and open sharing of plans, programs, and objectives. A post-conflict state dealing with different donor-funding mechanisms can become easily overwhelmed unless it has a comprehensive understanding of how each donor program contributes in the short- and long-term to the attainment of its health sector objectives. In Afghanistan, three different donor project schemes seem to be co-existing, albeit not without problems; in DRC, there is additional tension, but all recognize that there is reasonable potential for success; in South Sudan, severely limited government capacity, strategic shifts by USAID, and heavy reliance on national investment of local resources by the multi-donor trust fund are some of the reasons why many predict that progress will be slow.

Structuring Health Services

Because human resources are scarce in almost all post-conflict countries—either because they always were or because the conflict resulted in the flights of additional health professionals—it is often unlikely that a Ministry of Health, despite its wishes, would be able to fulfill its function of delivering health services to the population. The current trend in donor programming in post-conflict settings seems to be to leave health sector management to the public sector, but to allow for private sector delivery of health services. Contracting is one way of doing this that is being tried in a number of countries, including Afghanistan, Cambodia, and DRC. A recent review of this mechanism (Palmer et al. 2006) discusses its advantages and disadvantages.

The largest contracting experiment is being conducted in Afghanistan. There, USAID, the World Bank, and the European Community (EC) are each involved with varying forms of this mechanism. USAID has hired its own contractor (until recently, Management Sciences for Health, but soon to be the World Health Organization) to establish contracts with local NGOs, but in close collaboration with the Ministry of Health, to provide health services in accordance with the Ministry-approved BPHS. One of its principal objectives has been to strengthen local NGOs (civil society) through the provision of technical assistance. The World Bank, in contrast, has sought to strengthen the management capacity of the Ministry of Health by funding a Grants and Contracts Management Unit to award contracts to both international and national NGOs, again to implement services in accordance with the BPHS. The EC has followed its own contracting mechanisms. As the first phase of contracts is winding down, there is a tendency on the part of the donors to invest more in the Ministry of Health either through the provision of funds directly or indirectly and through the provision of additional

technical assistance directly to the Ministry. Independent evaluations that the Johns Hopkins School of Hygiene and Public Health conducted, on contract to the Ministry of Health (using World Bank funds), have shown that clear progress is being made, at least in terms of health service delivery, and the contracting mechanism has so far proven to be an effective one. As suggested above, however, the Ministry of Health has so far concerned itself only with health services management, and not with making a substantial and, perhaps more important, measurable contribution to the stabilization of the post-conflict peace process.

Encouraging contracting is certainly not the only way for donors to help to re-establish health services in post-conflict states. Many forms of structuring have been tried, but the documentation of successes and of failures remains skimpy. Most analysts would agree the long-term developmental goal would be to develop a SWAp-like approach, but clearly the desire is strong, probably appropriately, to retain reasonable control over funding during the post-conflict period. In a number of countries, therefore, donors that had contributed to a SWAp have withdrawn or earmarked their funds.

A final word is in order regarding funding and any assistance to fragile states in general and to post-conflict states in particular. To be successful, the funding level supporting health sector initiatives must be sufficient. There is a tendency to have great expectations of weak governments and Ministries of Health with limited means. The Commission for Macroeconomics and Health, the Millennium Project, the Disease Control Priorities Project, and others all suggest that a minimum of $15 per capita per year is required to implement a Basic Package of Health Services. While this amount is frequently available to fund services provided through emergency and humanitarian assistance mechanisms, it is strangely true that once an emergency is deemed to have subsided, health sector funding is often reduced, while funding is increased to develop other aspects of state functions, such as elections, justice, and other infrastructure areas. It should go without saying that without adequate funding, no form of health sector programming will be successful at bringing about important changes in population health status, nor will the health sector be able to make a significant contribution to improving either the legitimacy of a new government or its effectiveness.

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