FRAGILE STATES

BASICS III

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What is a fragile state?

Although there are many descriptions of fragile states, the two challenges they have in common are legitimacy (i.e., government will and capacity to provide core services and basic security) and effectiveness in providing services and security. These elements are interrelated in that the lack of capacity or willingness of governments to respond to the basic needs of people—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 to conflict.

In fragile situations, the essential institutions that help ensure that people's basic needs are met and look after those in greatest need are paralyzed and nonfunctional. It has been noted by some that many countries, such as in Africa, have never had functional government and service delivery systems, so nonfunctional government and systems have been the norm. 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—are no longer able to assist. Local capacity to deal with those situations depends on a modern state-level organization with access to adequate resources. Those resources have either never existed, they no longer exist, or violence and political instability have eroded the state's capacity to respond.

Fragile states and child health

The entire population of fragile states suffers, but particularly the children. For Millennium Development Goal 4, the child mortality rate in low- and middle-income countries is 56 per 1,000 live births while in low-income fragile state child mortality it is nearly 150% higher—138 per 1000[1]. Of all the global deaths of children under 5, half of those child deaths occur in fragile states, though fragile states only represent 14% of the world population.

[1] Department for International Development, "Why we need to work more effectively in fragile states", 2005, London: DFID.

The reasons of why fragile states are a concern to the international community:

- 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 occur in fragile states.
- A third of the population of fragile states is malnourished.
- A third of people living with HIV/AIDS are citizens of fragile states.
- Malaria death rates are 13 times greater in fragile states than in other developing countries.

USAID/BASICS' Involvement

The importance of health issues in fragile states resulted in U.S. Agency for International Development's Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition requesting that BASICS provide technical assistance in collaboration with the Bureau for Democracy, Conflict and Humanitarian Assistance /Conflict Management & Mitigation, and the Organisation for Economic Co-operation and Development/ Development Assistance Committee. This was part of a multi-donor exercise to deepen our understanding of health programming in post-conflict and fragile environments.

The documents from the series developed by BASICS are shown below.

BASICS Fragile States Series
(Click on titles to download documents)

- Health Programming for Rebuilding States: A Briefing Paper
- Health Programming in Post-Conflict Fragile States
- Providing Health Services in Fragile States
- Arrested Development in Fragile States: Opportunities and Guidance for USAID Programming
- Health Service Delivery in Early Recovery Fragile States: lessons from Afghanistan, Cambodia, Mozambique and Timor Leste
- Health in Fragile States Country Case Study: Democratic Republic of the Congo
- Health in Fragile States Country Case Study: Northern Uganda
- Health in Fragile States Country Case Study: Southern Sudan

Often, programming in these countries will require adaptation of health approaches so that they address key stabilization and resconstruction needs as well as public health needs. The increased importance of countries in or emerging from conflict within the broader context of instability and terrorism all demand special attention in order to develop a better approach to health sector actions within this larger scope.

A number of recommendations for health programming in fragile states are presented by the authors of this series. As suggested by Ron Waldman in *Health Programming in Post-conflict Fragile States*, there are essential common features to recognize. A useful way to understand these commonalities is to compare the three case studies provided in this series: Democratic Republic of the Congo, Southern Sudan, and Northern Uganda. In particular, each assesses the critical balance that needs to be struck—and the tension that exists—between programming to meet the emergency needs of a fragile state's population and programming aimed at building sustainable capacity in a health care system. An equally important shared theme is the role of donor harmonization in increasing program efficiency, recipient accountability, and coverage.

Specific means for actual provision of health services in these difficult environments were provided by William Newbrander to the OECD DAC Fragile States Group in London in *Providing Health Services in Fragile States.* This provides not only the challenges of health service delivery but also the elements of health system strengthening (HSS) that is needed in these situations. It also provides options for structuring and actual provision of services as well as donor financing of these services. Newbrander identified the key elements of health systems that require strengthening:

What Fragile State Health Systems Lack [2]

- **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
    - human resources for health

[2] Newbrander, W. 2006. p. 6 "Providing Health Services in Fragile States. Arlington, VA: BASICS

Finally, he provides the key lessons to USAID and other donors in the appropriate interventions in fragile states:

Summary: Key Lessons for Donor Interventions in Fragile State Health Systems [3]

- **Strategy**
  - Seek to **impact** 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.
  - Recognize changes in the environment and adapt accordingly **(flexibility).**
  - Promote **transparency and accountability.**
- **Engagement**
  - Provide **long-term expert presence** on the ground.
  - Staff must have **experience** and a **wide range of technical skills.**
  - Staff need to be held **accountable.**
- **Financing**
  - Provide **reliability** by committing to long-term financing.
  - Ensure **flexibility** in financing from relief to transition to development.
  - Be willing to cover **recurrent costs.**
  - Address **equity** concerns are met before financing.
- **Implementation**
  - Start with **basic package of health services** and expand the range of services over time.
  - Promote **system development.**
  - Make **evidence-based decisions.**
  - **Monitor** performance.

In *Health Service in Early Recovery States*, Laurie Zivetz summarizes helpful and unhelpful trends in assistance to fragile states, followed by a planning framework that emphasizes the proper sequencing of activities. A challenging rejoinder to this approach to program planning is offered by Ron Waldman, again in *Health Programming in Post-conflict Fragile States*. Citing evidence that improved security in a country is the most effective means to reduce excess mortality because it creates a favorable environment for health service delivery, he suggests that disease control programs need to be appropriately designed and implemented with non-disease control objectives in mind, as well. Waldman also explores this point in *Health Programming for Rebuilding States*, which provides an overview and commentary on the conclusions presented in all of the papers in this series.

[3] Newbrander, W. 2006. p. 13 "Providing Health Services in Fragile States. Arlington, VA: BASICS

"The Funding Gap"

The transition from relief to development marks a critical period for a country recovering from conflict. Affected residents, who have depended on humanitarian assistance during years of civil strife, can suddenly face reduced access to basic services such as safe drinking water, adequate shelter, or health care. Oftentimes, post-conflict governments have limited capacity and resources to meet these needs.
The goal of humanitarian assistance—to provide life-saving support and meet immediate needs—differs considerably from that of development—to ensure a sustainable system where a community can independently provide for its own needs. Bridging the gap between the two has long been a challenge for providers of both types of assistance. If development programs have not yet commenced as relief funding declines, an interruption in service provision could harm populations in critical need of assistance.

To minimize the potentially adverse impact for vulnerable communities in Liberia, OFDA is supporting the coordination of the post-conflict health sector transition. OFDA is working closely with USAID/Liberia and USAID's Bureaus for Global Health and Africa, enabling the Government of Liberia (GOL) to address urgent health needs while building capacity to restore vital, sustainable health services in a country emerging from 14 years of civil conflict.

By 2003, which marked the end of Liberia's civil war, 95 percent of health facilities had been destroyed or rendered non-functional, and no more than 20 trained Liberian doctors provided clinical care.1 In addition, merely 7 percent of people in rural areas maintained access to clean drinking water. Since FY 1990, OFDA has provided more than $106 million to assist conflict-affected populations in Liberia. Together with international humanitarian response to the emergency, this assistance has helped restore basic services, alleviate extreme poverty, and reduce high rates of infant and maternal mortality.

While Liberia no longer faces immediate needs as a direct result of the conflict, the country confronts immense and ongoing challenges that could take years to offset. The Liberian Ministry of Health and Social Welfare (MOHSW) suffers from limited financial, material, and human resources, and NGOs still operated more than 70 percent of health facilities as of June 2007. As humanitarian agencies begin to reduce their activities, Liberia could face a gap in basic health services and a decline in overall funding, which together could result in further service disruption and reduced access to health care for Liberians. The transition gap, if unaddressed, could adversely affect 2.7 million Liberians, as only 36 percent of functioning health facilities have secured funding through the end of 2008.

In FY 2007, OFDA, along with State/PRM and USAID/Liberia, funded the ongoing operation of 101 of the 300 NGO-supported health facilities in Liberia. As USG assistance transitions from humanitarian to long-term development, USAID is working with MOHSW to ensure the continuity of health service delivery and to support the development of a national health system. Setting the transition process into motion, OFDA supported two workshops in Monrovia, one in April 2005 and another in August 2006, which was co-hosted by USAID, MOHSW, and WHO. These workshops facilitated discussion about consolidating health services and improving the transition process and fostered collaboration among the various actors in the Liberian health sector, including USAID, U.N. agencies, NGOs, MOHSW, and health teams from all of Liberia's 15 counties.

Following the workshops, OFDA funded USAID's Basic Support for Institutionalizing Child Survival (BASICS) project to better determine the scope of the health transition gap and to provide coordination, technical assistance, and support for the transition process in Liberia. As part of the project, BASICS assisted MOHSW to develop Liberia's National Health Policy and Plan to guide the implementation of health services at the county level.

Setting the foundation for Liberians to continue accessing essential heath services, the BASICS project used a novel approach: a systematic survey, funded by OFDA, which assessed the relative public health impact of USG-funded clinics. The BASICS survey numerically ranked the public health significance of each USG-funded facility according to geographic location, population, service utilization, staffing patterns, services delivered, demand for services, equipment, medical supplies, infrastructure, and operating budget. Based in part on the survey results, OFDA, in conjunction with USAID/Liberia and implementing partners, decided where and how to continue funding health clinics during the transition. Correspondingly, since the results of BASICS' analysis indicated that each of the USG-funded facilities remained critical for Liberian families in need of health services, OFDA has ensured the continued funding of these health clinics through July 2008 and identified other donors to support previously funded OFDA clinics. As an outcome of the assessment, OFDA and our partners are shifting from funding individual clinics to supporting a broader health system at the county level.

Based on the results of BASICS' analysis, OFDA supported a series of workshops in June 2007 to build the capacity of county health teams and strengthen service delivery. Striving to develop human capacity and enhance partnerships, the workshops emphasized community involvement to build public confidence in Liberia's health system. These workshops played a pivotal role in encouraging county-level leadership and planning, preparing MOHSW and NGOs for the health transition, and supporting the implementation of the new National Health Policy and Plan.

Through a process initiated during the emergency phase, OFDA and USAID/Liberia have formulated a strategy for transition to development funding that mitigates harm to vulnerable Liberians in urgent need of health care. By collaborating with the GOL and key stakeholders to systematize health care provision and create a basic package of health services, OFDA has helped to identify essential activities for continuation during the transition. In the future, OFDA plans to use the transition gap analysis in Liberia as a model approach for other post-conflict countries shifting from an emergency context to long-term development.

After developing and applying the approach to assessing potential "transition gaps" during the shift of Liberia's health sector from relief funding to development funding, BASICS received a request from the U.S. Government's Office for Foreign Disaster Assistance to undertake a similar analysis in Southern Sudan. Conducted from August 2007 to March 2008, the Southern Sudan evaluation was an important part of efforts to preserve access to care and minimize deterioration of health indicators in the country.

Click here to download *Health System Transition and the Transition Gap in Liberia a Report to the Office of Foreign Disaster Assistance*.

Conflict and Post-Conflict States Seminar

BASICS hosted a technical seminar, “Conflict and Post-Conflict States: Perspectives on Health Development” in September 2009. The seminar addressed several questions:

- What are the key health development and security issues in conflict and post-conflict states?
- Why is it critical to develop the health systems and increase the access to health services in conflict and post-conflict states?
- How is health development impacted in states with a military presence?

The presentations are available in the table below:

Perspectives on Key Issues of Health Development in States in Conflict and Post-Conflict States			
What is the current range of thinking on global health issues in the context of health development in conflict and post-conflict states?	Gene Bonventre, CSIS Working Group on National Security and Global Health	Click here for presentation slides	Click here for audio recording
What has USAID learned as the approach to health development in conflict and post-conflict states has evolved?	Carl Abdou Rahmaan, Senior Country Affairs Officer, USAID Afghanistan-Pakistan Task Force	Click here for presentation slides	Click here for audio recording
What are the principles and strategies of the US government for reconstruction and improving health in conflict and post-conflict states?	Robert Jenkins, US Department of State, Office of the Coordinator for Reconstruction & Stabilization		Click here for audio recording
Lead or complementary role—what can the military contribute to development in conflict and post-conflict states?	Tim Challans, Military planner	Click here for presentation slides	Click here for audio recording
Perspectives from the Field in Conflict and Post-Conflict States			
Multi-country perspective: What role can the government play in rebuilding health systems in post-conflict states?	Enrico Pavignani, WHO advisor on post-conflict countries	Click here for presentation slides	Click here for audio recording
Liberian perspective: What should donors do or not do in a post-conflict states	Tornorlah Varpilah, Liberian Ministry of Health & Social Welfare	Click here for presentation slides	Click here for audio recording
Afghanistan perspective: Yesterday and today—how have the issues for improving health changed due to the insurgency?	Gary Cook, USAID	Click here for presentation slides	Click here for audio recording
What are the key elements to success or failure in health development in conflict and post-conflict states?	Bill Newbrander, USAID/BASICS	Click here for presentation slides	Click here for audio recording
Discussion on Health Development Issues in Conflict and Post-Conflict States			
Final observations: The road ahead for health development in conflict and post-conflict states.	Gene Bonventre and Bill Newbrander		Click here for audio recording

As noted at the conclusion of the event, decision makers are used to drawing a clear distinction between development and emergency relief or humanitarian assistance. An important question is: what do you do when working in a structure that is neither humanitarian assistance nor development? Health is one complex system in a much bigger, much more complex system. Health planners need to be aware of the political dimensions of their work and then figure out how their programs fit into these bigger systems, and also how our programs support these systems.

It was also stressed that tension that exists between short-term, quick impacts that satisfy what the public wants versus long-term needs; especially public health needs. Assistance is not necessarily a zero-sum game, though; it’s necessary to look for synergies where one can support the other and reduce conflict between the two.

The importance of planning at a decentralized level was stressed so as to take into account local political contexts, whether at the sub-regional or sub-national level; instead of imposing a top-down, centralized model.

Ultimately, strengthening health systems in fragile states is much the same challenge in as it is in any developing nation. It requires similar emphasis on coordination between donors and governments, as well as a flexible approach to implementation. In the particular case of fragile states, there remains a lot of research to do to understand how well strengthening efforts are succeeding in terms of implementation quality, effectiveness, and outcomes. The lessons gained from such research will improve programs in fragile and developing nations alike.