

# Rebuilding and strengthening health systems and providing basic health services in fragile states

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*The international community has compelling humanitarian, political, security and economic reasons to engage in rebuilding and strengthening health systems in fragile states. Improvements in health services and systems help to strengthen civil society and to restore legitimacy to governments. Effective engagement with fragile states to inform the design of health programmes and selection of interventions depends on donor coordination and an understanding of health system challenges. Planning requires consideration of allocation (services to be delivered), production (organisation of services), distribution (beneficiaries of services) and financing. The criteria for selecting interventions are: their impact on major health problems; effectiveness; the possibility of scale-up; equity; and sustainability. There are various options for financing and models of engagement, but support should always combine short-term relief with longer-term development. Stakeholders should aim not only to save lives and protect health but also to bolster nations' ability to deliver good-quality services in the long run.*

**Keywords:** Afghanistan, Democratic Republic of the Congo, fragile states, health system strengthening, humanitarian relief work, Liberia, rebuilding health care systems, urgent health needs, war

## Introduction

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 better the use of resources, and efforts to deal with the consequences of a lack of coordination or long-term commitment to the process needed to 'fix' fragile states.

The health of such states, their people, and their health systems depends in large part on meeting urgent health needs, carrying out quick-impact and medium-term responses, as well as addressing the longer-term development and strengthening of health systems.

The transition stages proposed in this paper are applicable even in the disaster that resulted from the earthquake in Haiti in January 2010. In Haiti, after immediate needs are dealt with, it will be necessary to plan longer-term health system development and reform. Such a disaster can be an opportunity for giant leaps forward in terms of strengthening the health system, as compared to the gains of the past, which were slow because of entrenched interests.

## **Background: characteristics of fragile states and the importance of rebuilding and strengthening health systems**

This overview contains definitions of fragility, describes typologies used to analyse 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.

**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 government to work in the interest of the public and to demonstrate fairness to all groups. *Effectiveness* means the ability of government to maintain security and order and to 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, health, sanitation, security, shelter and water—means that people feel betrayed by government ineffectiveness (OECD, 2008).

**Typologies used in analysis.** 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.

**The components of fragility in health systems.** Focusing on the elements of government that apply to the health sector, the six basic structural components of a state are:

- delivery of essential services;
- resource management (human and financial resources, facilities, and drugs, supplies and commodities);
- financing;
- critical data needs;
- stewardship and accountability; and
- security.

Although states vary in regard to these components, usually they can be analysed according to their current condition and the direction in which they are moving (that is, towards greater or reduced fragility). 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. Another country might exhibit some elements of a collapsed state with respect to

accountability, resource management, and financing but show positive signs in delivering services and exercising stewardship.

These characteristics of a state are closely related to the necessary characteristics of health systems, as defined by the World Health Organization (WHO)'s six building blocks required for an effective health system (WHO, 2007):

1. Good **health services**;
2. Well-performing **health workforce**;
3. Well-functioning **health information system**;
4. Equitable access to **medical products, vaccines and technologies**;
5. Good **health financing**; and
6. Solid **leadership and governance**.

**The importance of fragile states to the international community.** The international community has legitimate political, security and economic reasons to become engaged with fragile states. Fragile states represent instability that can spread to pose dangers throughout a region, destabilising neighbouring countries. They can be a source of mass migration of people. Internationally, there is also concern that fragile states can threaten global security by becoming incubators for international terrorism and crime. They may be a drag on the global economy, so there is interest in increasing global health and productivity by helping them (DFID, 2005).

**Health is an essential part of assisting fragile states.** The burden of disease and the mortality levels experienced by the populations of fragile states are extraordinarily high:

- more than one-third of maternal deaths worldwide occur in fragile states;
- one-half of the children who die before the age of five live in fragile states;
- one-third of the people in fragile states are malnourished;
- one-third of people living with acquired immune deficiency syndrome (AIDS) are citizens of fragile states; and
- malaria death rates are 13 times greater in fragile states than in other developing countries (Chakrabarti, 2004; Nabarro, 2004).

High morbidity and mortality rates may contribute to fragility. But the state's ineffectiveness in delivering social services also is a cause of poor health indicators. The collapse of the health system in these countries makes it easier for disease and epidemics to spread, meaning that states cannot recover without outside assistance.

Relief agencies and donors should be involved in providing health services in fragile states because of the humanitarian imperative to act in the face of crises that result in high rates of disease and death and in the destruction of food sources, people's homes, and other basic survival needs. Health service delivery also can be a good entry point for tackling the causes of fragility because health services can lead to involvement with both the government and civil society. The engagement of entities such as non-governmental organisations (NGOs) plays a significant role in

expanding access to basic health services. At the same time, involving civil society can strengthen the government and help move it towards reform in other areas. Thus, assistance in health, as well as in other social sectors such as education, can serve as a platform for initiating longer-term development activities.

As noted in the Basic Support for Institutionalizing Child Survival (BASICS) Project study in the Democratic Republic of the Congo (DRC), there is a link between insecurity and poor health (Waldman, 2006). Even though violence was not a significant cause of death, overall mortality rates and child mortality rates were much higher in health zones where there was armed conflict, as compared to health zones where there was peace and security. So disease might not be the major cause of mortality (Waldman, 2007).

At present there is a lack of evidence to corroborate the existence of linkages between health and improved stability in fragile states. A 2008 study that sought to define a research agenda for identifying if there was a connection between health system strengthening and state-building in fragile states specified as a hypothesis:

*[B]uilding health systems contributes to wider state-building by helping to strengthen state capacity and by signalling the increased willingness of the state to act on behalf of citizens in a responsive and accountable manner. This generates enhanced support for the state in return (legitimacy) and a stronger social compact between state and society. Furthermore, the planning, management and delivery of health services throughout a state is inherently interdisciplinary and contributes to capacity development beyond the health sector (Eldon, Waddington and Hadi, 2008, p. ii).*

More research is needed to establish the existence and degree of such linkages. However, it is often the humanitarian imperative to respond to a large crisis that has a major impact on health in a fragile state that is the basis for international action in such countries.

## **Health service delivery and health system development and strengthening in fragile states**

Although disease outbreaks or high mortality rates must be the short-term focus in many fragile states, it is essential to start planning at the same time for the transition to longer-term development of the health system. This dual focus requires addressing the elements of a dysfunctional health system and how it can be rebuilt while dealing with immediate health priorities. This two-pronged approach can be seen in several countries.

### **Examples of applying short- and long-term approaches simultaneously**

In Liberia, the government, donors and health partners worked together to coordinate in the post-conflict period of 2006–09. They had a dual focus on maintaining

access to care and rebuilding the health system. Donors continued to fund humanitarian assistance partners to provide basic services several years after the conflict had ended. This continuity gave the Ministry of Health and Social Welfare (MOHSW) the opportunity to concentrate on coordinating system-strengthening activities such as developing national pre- and in-service training programmes and instituting a facility accreditation process. This window of opportunity also provided time for development donors and partners to work with the MOHSW to design projects that met national long-term strategic objectives.

In Afghanistan—an extremely fragile state due to prolonged political instability aggravated by natural disasters including earthquakes, floods and drought—a ‘golden opportunity’ emerged in 2002 to rebuild the health system without the encumbrances that often affect other countries trying to rebuild and reform their health systems. Yet there was a dichotomy: areas that enjoyed relative stability after the departure of the Taliban required rehabilitation and longer-term planning, but in areas characterised by war and insecurity, only emergency services were feasible initially. Therefore the Ministry of Public Health (MOPH) had to provide relief services to address the emergency health situation, while also planning for the future by rebuilding the national health system. The MOPH 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.

In the DRC the co-existence of humanitarian and development programmes is necessary because of continued conflict in the eastern part of the country, which demands a relief approach to service delivery. In the rest of the country, however, the government and donors are focused on longer-term strategies to rebuild the health system.

**Deficiencies of the health system.** Many states emerging from conflict face the same health system problems that other non-fragile developing countries confront. Some states are fragile in both conflict and non-conflict situations; it is just a matter of degree. But for others the conditions of fragility or conflict create a special set of circumstances that need to be addressed as the health system is rebuilt. Typically, in fragile states the health system is characterised by:

- inability to **provide health services** to a large proportion of the population outside urban areas;
- ineffective or nonexistent **referral systems** for the critically ill;
- a lack of **infrastructure** (including facilities, human resources, equipment and supplies, and medicines) for delivering health services—what did exist has been destroyed or severely compromised due to war and/or neglect;
- nonexistent or inadequate **capacity-building mechanisms and systems**, such as national clinical training programmes, to address the dearth of clinical and management capacity;
- insufficient **coordination, oversight and monitoring** of health services by the emerging government, which may not have the capacity to manage;

- a lack of **equity** in who receives the available health services: few public health services exist for the poor and in rural areas;
- a lack of **policy mechanisms** for developing, establishing and implementing national health policies;
- non-operational **health information systems** for planning, management and disease surveillance; and
- inadequate **management capacity and systems** (such as budgeting, accounting and human resource management systems) for controlling resources.

In determining what interventions and assistance can be provided to the fragile state, the real challenge is the requirement to tackle these interlinked problems concurrently based on national health objectives and priorities, defined by health leaders who have a common vision of the health system that they wish to rebuild.

### Examples of deficient post-conflict health systems

The health system in southern Sudan had been seriously compromised by decades of conflict and neglect. Before the war, isolation prevented the establishment of an effective, accessible health system, and the two decades of conflict rendered the delivery of health services to the majority of the population almost impossible. In 2007, the United Nations (UN) estimated that NGOs, financed by international donors, were responsible for 86 per cent of all health care delivery in southern Sudan. There were an estimated 750–800 functional health facilities in southern Sudan (Shepherd-Banigan et al., 2008). Nevertheless, only 25–30 per cent of the population had even minimal access to health care. As a result, morbidity and mortality rates in southern Sudan were among the highest in the world: in 2007 the infant mortality rate was estimated to be 150 per 1,000 live births and the under-five mortality rate was 250 per 1,000 live births.

In 2004, Liberia also had one of Africa's highest under-five mortality rates: 249 per 1,000 live births for males and 200 per 1,000 for females (WHO, 2006). This suggested that there were serious deficiencies in the health system. Therefore, in the early post-war period (2006), the Liberian MOHSW conducted a rapid assessment of the health sector. It found that there were 354 health facilities in the country and that each facility served approximately 10,000 people. The quality of systems required to manage the delivery of services, such as health management information systems and supervision, was extremely poor. In addition, the drug supply was dependent on non-governmental actors, such as NGOs. The Liberia Rapid Health Sector Assessment also revealed a significant gap in funding. For instance, only 15 per cent of health facilities reported that they had funding guaranteed through the remainder of 2006.

### Examples of how to address health system deficiencies and establish national priorities

The results of the Liberia Rapid Health Sector Assessment were presented at a strategy workshop in 2006 and used to design an implementation plan for the health

sector that addressed the specific gaps in post-conflict Liberia. The national health plan was structured around four components: the Basic Package of Health Services; Human Resources; Infrastructure; and Support Systems. This framework was used to align stakeholder efforts with national goals and priorities, and it helped to maintain a focus on tackling the deficiencies in the health sector simultaneously.

In November 2004 the Government of the DRC presented the Minimum Partnership Program for Transition and Recovery (PMPTR) to donors. The PMPTR was a strategic framework based on government priorities for the reconstruction of the health system. Priority actions included the revitalisation of the health zones and the development of health system capacity (Waldman, 2006).

**Priority interventions.** Needs in fragile states are so great that often it is difficult for a country to know what it should do first to deal with urgent requirements while also putting in place the foundation for longer-term development of the health system. Reviews of different situations in states at various stages of fragility have led to some prioritisation of actions to respond to immediate needs as well as to prepare for rebuilding the health system. There are 10 priorities for assisting the health ministries of fragile states (Newbrander, 2007):

- address urgent health needs;
- gather information;
- create a package of basic health services;
- develop policies, strategies and plans;
- build up human resources for health;
- ensure that there is a regular supply of essential drugs;
- finance services adequately;
- redevelop and reform the health sector;
- rehabilitate or reconstruct health facilities; and
- coordinate donors.

### Examples of how priority interventions were addressed in post-conflict countries

In Liberia the MOHSW-led process to rebuild the health system addressed the majority of these priority actions. The MOHSW encouraged donors to continue providing assistance to humanitarian assistance organisations and at the same time to initiate funding to development organisations to avoid any gap in service provision. The results of the 2006 assessment yielded sufficient information for the MOHSW to define the National Health Policy, Health-Sector Implementation Plan, and Basic Package of Health Services. These documents helped to coordinate stakeholder activities around identified priorities. Eager to restore effective, high-quality health interventions, the MOHSW also reformed the health sector with respect to concepts such as decentralisation and primary health care to provide the foundation for equitable access to care.

In Afghanistan, beginning in 2002, the MOPH focused on reducing the mortality of women, infants and children by seeking to increase access to critical health services. Simultaneously, it began developing the Basic Package of Health Services, which defined its priorities, and initiated a countrywide survey of all of the health facilities and health staff in the country so it would have the information needed to begin planning of the health system. It continued to progress through the list of priority interventions in order to deal with the immediate, short-term and long-term needs for establishing a functioning health system.

**Developing tools to assist in assessments and interventions.** Many post-conflict countries lack the information to support the data-driven decision-making that is essential when they are determining how to prioritise resources. Hence, in many cases there is a critical need to collect information, and this may require the development of new tools and methodologies.

In Liberia, the United States Agency for International Development (USAID) commissioned BASICS to design and conduct a funding gap analysis to evaluate likely donor inputs for health between 2006 and 2008. The gap analysis was focused on funding to support the transition from emergency humanitarian aid to development resources for health and provided recommendations for future planning and action by the MOHSW and the Government of the United States. Findings of the analysis revealed that in October 2006, 77 per cent of functioning facilities were run by NGOs and faith-based organisations and funded primarily by humanitarian assistance donors. The data also highlighted that by the end of 2008, the majority of humanitarian assistance contracts were due to end, and without additional funding only 30 per cent of existing facilities would continue to function. Before this study, the MOHSW had no information about when implementing partners' contracts would expire. The information collected through this exercise demonstrated the need for a continued NGO presence in the near-term and the importance of a coordinated handover between humanitarian assistance donors, the development community, and the MOHSW. Finally, this process emphasised the need to advocate for additional funding to support existing health service delivery and to assess the most efficient use of reduced funds to maximise access to care (Shepherd-Banigan et al., 2007). The results of the evaluation were presented at the Liberia Health Sector Partnership Forum, held in Washington, DC on 16 February 2007, and resulted in a USD 10 million commitment from the World Bank for the Liberian health sector.

As part of its technical assistance programme to address child survival in the context of humanitarian crises, BASICS also developed a tool to analyse the decentralised management of health services in fragile environments during the transition from relief assistance to development aid. The tool was designed to assess the capacity of the health system to manage health service provision effectively. The methodology collected information on factors that support the devolution of management from the central to provincial level and enable health authorities to manage a decentralised system effectively, including skills, resources, and organisational and political structures. The tool was piloted in Liberia in July 2009 in six of the country's 15

counties and provided information on the process of decentralisation to support planning for government and partner capacity-building activities (Peercy and Shepherd-Banigan, 2009).

In Afghanistan, one of the key tools developed for prioritising needs and formulating the Basic Package of Health Services was the Public Health–Based Decision Tool. This tool assisted the MOPH in (1) establishing priorities, (2) developing criteria for making choices among alternatives, (3) ensuring that policy decisions are consistent with national health objectives, and (4) making sure priorities were maintained. The Public Health–Based Decision Tool consists of five key questions related to ensuring a positive outcome in addressing major health problems, which is the overarching concern of health programmes (Afghanistan Ministry of Public Health, 2005):

- Do the services proposed have an **impact** on the major health problems?
- Does the intervention have proven **effectiveness**?
- Can the intervention be **scaled up** to be implemented on a national **scale**?
- Is the intervention **affordable** in the long term (sustainability)?
- Will **access** to and the **benefits derived from** the intervention be fair to all (equity)?

The MOPH used this tool to guide it in making major decisions about policies, interventions, and offers of assistance from donors.

## Health system development and strengthening in fragile states: challenges and lessons

Donors frequently experience difficulty in handling the transition from emergency humanitarian assistance to development. For example, financing mechanisms, management approaches and administrative procedures may vary greatly between humanitarian aid and development aid organisations, create confusion, and inhibit a smooth transition. In 2006, donors in the DRC stated that they had not been able to transition adequately from relief to development in part because the government and health actors had not managed to design programmes that addressed the unique challenges of the relief-to-development transition.

A few principles can help. Because health is part of a larger picture, donors' actions in relation to ministries of health should not entail drastic changes that have political implications. Instead, donors should restore, repair and build on the health system elements that worked well prior to fragility and should design health programmes that respond to the special circumstances in fragile contexts.

### Examples of transitioning from emergency to development

If the transition from emergency to development is not coordinated and smooth, it can result in a significant decrease in services. For example, in southern Sudan in

2007 many relief NGOs proposed to withdraw from facilities because of decreased humanitarian funding and their humanitarian assistance mandate, which did not support continued involvement in post-conflict situations. In some cases service provision was transitioned to the state Ministry of Health (MOH) or the County Health Department. In other cases, NGOs handed service delivery over to other NGOs. The most successful transitions, during which facilities continue to operate at an equal or improved level, were those in which service delivery was transitioned to other NGOs. However, even in these cases there were gaps in service delivery. Transitions to the state MOH and County Health Department were not successful because of a lack of qualified staff, minimal salary support, drug stock-outs and increased pressures on the health sector from returning populations.

### Examples of building on previous health system elements

In Liberia the MOHSW and partners worked deliberately to uncover the existing foundations of the health system. This work provided a way to establish quickly a consensus on rebuilding and reforming the health system and to begin swiftly the development of the National Health Policy. The cornerstones included the Health Policy (2000), Decentralisation Guidelines (1986), and the concepts of primary health care and decentralisation. Focusing on these elements accelerated the finalisation of the National Health Policy and Plan through avoidance of delays associated with developing a common vision and framework.

Due to the progressive health policies instituted in 1981, the health system in the DRC was considered to be one of the best in Africa until conflict broke out in the mid-1990s. Since 2002 health sector reconstruction has utilised several approaches that were successful in the past, including revitalising the health zone model and working through public-private partnerships with churches and NGOs.

Donors also need to develop flexible aid instruments that can deal with humanitarian crises and development simultaneously. Furthermore, the lack of absorptive capacity in most fragile states to manage effectively 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 to develop a policy process. Finally, the alignment and coordination of multiple donors assisting a fragile state are critical.

### Examples of a lack of absorptive capacity

A lack of absorptive capacity, particularly at the provincial level, is a major challenge to rolling out health services in decentralised health systems. In Uganda, for example, the United Nations Children's Fund (UNICEF) worked in the province of Gulu in direct coordination with the district level. To build the capacity of the district health system, UNICEF wanted to channel funds directly through the districts, but a lack of administrative capacity impeded this process (Rowley, 2006).

## Examples of donor coordination

The alignment and coordination of multiple donors across the levels of the health system can pose major challenges to newly elected or established governments. Often, donor coordination efforts are little more than superficial attempts to exchange information about activities without meaningfully involving the government or other actors. In the DRC a lack of coordination resulted in one partner shifting its geographic focus to another area that already received external support, leaving several health zones without assistance (Waldman, 2006). Donor coordination mechanisms and tracking systems are necessary to support this process and provide coherence to the task of rebuilding the health system.

Several innovative donor coordination mechanisms have been employed in various countries. For example, the Government of the DRC used the health zone to focus donor activities in geographic areas. The Basic Package of Health Services also served to harmonise partner initiatives.

In February 2007 the MOHSW, USAID and the World Bank sponsored the Liberia Health Sector Partnership Forum in Washington, DC. The purpose of the gathering was to provide an opportunity for the MOHSW to present the Liberian National Health Policy and Plan to the international community. In addition it was intended to broaden the network of partners and support for the health sector to strengthen capacity to address challenges and secure the resources needed to implement the National Health Policy and Plan. The MOHSW also hosts a monthly meeting in which health partners share information on new policies and check that their activities and plans complement and support what is happening within the MOHSW. Furthermore, there is a National Annual Review Health Conference that all partners and central- and county-level MOHSW personnel attend to review progress made on the National Health Policy and Plan.

In Uganda the Joint Review Mission, National Health Assembly, and the Health Policy Advisory Committee are all examples of donor coordination mechanisms that support health programming.

Partner tracking mechanisms are equally important in providing a context for donor coordination. The early work of BASICS in Liberia to quantify the transition gap resulted in a facility database that tracked financial support over time. The MOHSW used this database to identify innovative ways to coordinate and align partners. For instance, an analysis of donor assistance in 2007 found that primary donors (those who were assisting 50 per cent or more of the health facilities) could be identified. BASICS proposed an approach to pinpoint a primary donor for areas of emphasis within each county. USAID explored this approach in an effort to target assistance in five geographic catchment areas and used it to define catchment areas for the Rebuilding Basic Health Services Project, begun in 2008, which is responsible for building the capacity of county health teams to implement the National Health Policy and Plan and coordinate service delivery in those counties. This approach is an example that the MOHSW and other governments can use to organise donors within specific geographic areas to coordinate donor inputs in a way that supports national priorities.

**Principles of effective donor engagement in fragile states.** To develop an effective, sustainable and resilient health system, donors and those who supply technical assistance should take a strategic approach whose goal is to have a positive impact on the lives of those in need. Effective engagement should assist an MOH in developing the health system by simultaneously building up its key elements. The partnership of donors with an MOH must address not only the essential services needed to respond to immediate health needs but also help to create the foundation that will allow government to build a solid health system that tackles national health priorities. Donors can assist ministries by:

- starting with a **package of basic health services** and expanding them over time;
- building the **capacity** of public- and private-service providers;
- strengthening government **management** of the health sector;
- considering **sustainability** in the light of state fragility;
- promoting **transparency and accountability** of results;
- providing a long-term **expert presence** on the ground;
- making a **commitment** to long-term financing and ensuring **flexibility in their financing** of the transition from relief to development;
- promoting **system development**;
- **collecting and using information** for decision-making and conducting regular performance monitoring; and
- ensuring **coordination** with other donors.

**Challenges for structuring health service delivery in fragile states.** The rapid roll-out of affordable, accessible and high-quality health services can have a major impact in terms of 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 behaviour, resulting in more attention to equity issues. Technical assistance and capacity-building can help to lay the foundation for a functional health care system and the management capacities required to sustain this element of state responsibility in the long term.

A model for the provision of health services in developing countries in the World Bank's *World Development Report 2004* points up three key actors: the state's policymakers; the health service providers; and the population or clients. The latter are both the recipients of services from providers and the constituents of government policymakers. The policymakers establish the structure of the health sector, which will either provide services directly to the population or use a mixture of public and private providers to deliver services. The amount of financial resources available for providing services is not as critical as the way in which the health service delivery system is organised. Whatever mechanism is chosen, the state's stewardship role requires that it serve as overseer and regulator of the health sector, even if the private sector supplies all health services.

When one or more of the linkages among these actors is broken, there is a problem with service delivery. In such instances, there will be few control mechanisms, meaning that health care providers may not be responsive to clients. To compound this problem, the number of health care providers in fragile states is frequently insufficient. Finally, insecurity can prevent the equitable delivery of services.

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

- **Allocation:** what health services are to be delivered?
- **Production:** how are the health services to be organised and produced?
- **Distribution:** who will receive the services?
- **Financing:** who will pay for the services and how will providers be paid?

The answers to these questions will determine: whether the health system will focus on curative or preventive services; whether there is equity in the health system; whether services reach rural areas or only the urban population; and who will bear the cost of the health system as well as the payment incentives that influence how providers deliver services. Over time the responses may change as the state shifts from dealing with the humanitarian crisis to developing a functioning and sustainable health system.

### Examples of how these questions were addressed in Liberia and Afghanistan

In Liberia and Afghanistan, the emphasis on primary health care and equitable delivery of quality services influenced how these questions were answered. In both countries a Basic Package of Health Services was developed to align government and donor health activities and to ensure that essential services were delivered in all facilities throughout the country. Decentralisation, a key theme, meant that services were delivered at all levels from hospitals to the peripheral health centres. In both countries, there was also a strong emphasis on community health programming and participation. Hence, community health service programmes were initiated during the post-conflict period. The Government of Liberia declared that all basic services, including health and education, would be provided free of charge. Since it did not have the resources to fund health care nationally, it chose to continue the delivery of services through NGOs with international assistance.

**Prioritising health services to be provided.** As in Afghanistan, countries must develop criteria for selecting the interventions and health services that are to be provided to the population. The primary concern in determining priorities and the content of health programmes is whether the services proposed will address major health problems. To determine whether a public health intervention will succeed in addressing major health problems that affect the health status of a population, governments and donors can apply five criteria:

- **Impact:** do the services proposed tackle the major health problems?
- **Effectiveness:** does the intervention have a proven track record of working in other countries to solve this health problem?
- **Scaling-up:** can the intervention be implemented on a large (for example, national) scale?
- **Equity:** will access to and the benefits of the intervention be fair to all?
- **Sustainability:** is the intervention affordable in the long term?

Afghanistan, the DRC, Liberia, southern Sudan and Uganda are all examples of fragile states that have developed a Basic Package of Health Services to guide the implementation of health services. The package documents contain descriptions of interventions and the equipment and commodity needs at each level of the health system and are tailored to the specific burdens of disease in each country.

**Financing health services.** Options for donor financing of health services have different advantages and disadvantages and can be used in combination. However, it is important that health sector financing be aligned with nationally-approved activities and priorities. These options include:

- **general budgetary support earmarked for the health sector:** donors have been most willing to use this mechanism when there is a trust fund operated jointly by a multilateral agency and the national finance ministry;
- **sector-wide approaches (SWAs):** SWAs constitute a mechanism for harmonising donors while pursuing alignment with government priorities. They are meant to facilitate strong government ownership and leadership of the health sector by transferring decision-making to the developing country. One difficulty in employing SWAs in fragile states can be the weakness of the government in managing such coordination;
- **contracting:** contracting NGOs is being used as a mechanism to provide health services to large populations in a number of fragile states. Contracting can serve to expand health services quickly, although some observers have concerns that such an arrangement may bypass government mechanisms if donors provide contracts or grants directly to NGOs. However, the example of Afghanistan, presented below, demonstrates that this worry may be unwarranted.
- **performance-based financing (PBF):** PBF, which links payments to the achievement of measurable results, has been successfully applied in Haiti, Rwanda and other countries to expand services (Eichler et al., 2009; Rusa et al., 2009);
- **global health partnerships (GHPs):** GHPs can aid fragile states in filling gaps, such as restarting a national tuberculosis (TB) programme with a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Potential disadvantages are that such programmes may not be integrated into basic health services, may not be sustainable, or may not provide support for health system development. Advantages of GHPs include avoiding duplication of investments and activities, producing economies of scale, pooling resources to make it possible to carry out higher risk activities than any partner would undertake alone, sharing knowledge

to improve the effectiveness of activities, and building a common 'brand' that gains legitimacy and support.

### Examples of financing mechanisms

Afghanistan, the DRC, Liberia and southern Sudan have selected contracting as the primary mechanism to finance the health sector. A lack of national resources has resulted in continued reliance on international donors to fund NGOs to provide health care. However, in several countries, donors and governments are working together in innovative ways to build the capacity of ministries of health to manage and administer funds to NGOs. In Liberia, for instance, the MOHSW has instituted an Office of Financial Management within the department to administer a pooled fund that manages funds from several donors, including Irish Aid and the United Kingdom's Department for International Development (DFID). The MOHSW will use some of the resources to pilot a contracting scheme to fund directly provincial health teams to deliver basic services.

Afghanistan's contracting of health services has served as an example to other fragile states (Palmer et al., 2006). The MOPH and donors agreed in 2002 that access to health services could be expanded more quickly, and more efficiently, if the MOPH contracted NGOs for the provision of health services and asserted its stewardship role (Waldman, Strong and Wali, 2006). Initial concerns about contracting have proven to be largely unfounded, and the Basic Package of Health Services was delivered at the cost originally expected in 2002: USD 4.50 per capita per year (Newbrander, Yoder and Debevoise, 2007). An indicator that the management, monitoring and financial systems had become sufficiently developed manifested itself in 2008 when the US Administration signed an agreement with the Government of Afghanistan that committed USD 218 million for the funding of basic health services for 13 provinces for five years through direct budgetary support to the MOPH through the Ministry of Finance. This arrangement represents the first time that USAID has directly provided funding of this amount to a host nation.

The Government of the DRC has contracted private-sector entities to deliver health services. For example, the World Bank's Health Sector Rehabilitation Support Project (PARSS) utilises performance-based contracts between the MOH and implementing partner agencies to meet national health performance targets (Waldman, 2006).

In southern Sudan, the Multi-Donor Trust Fund (MDTF) was established in 2006. MDTF was a basket fund mechanism administered by the World Bank to which donors pledged USD 252 million to support the development of southern Sudan. The Umbrella Program for Health (the MDTF health project) supported the health sector by developing health system capacity and increasing access by the population to basic health services. The MDTF gave the MOH the opportunity to issue contracts to partners to address specific health priorities. Unfortunately, in 2007 many health partners reported that the process lacked transparency and sufficient resources to achieve expected outcomes. Two of the major issues were a dearth of human resources and a high staff turnover rate within the MDTF, contributing to chronic

delays and erosion of confidence in the initiative. This situation is an example of how innovative financing mechanisms can fail if they are not transparent and well-managed.

In Uganda, several major donors channelled their health resources through SWAPs to support the government's health budget for long-term health planning. This effort promoted the harmonisation of donor funding. One case study (Rowley, 2006) reported that the Government of Uganda and some donors preferred this financing method. Other donors who did not participate in this mechanism, such as USAID, were unable to provide information to the government on the amount of funding available during the national health budgeting and planning process.

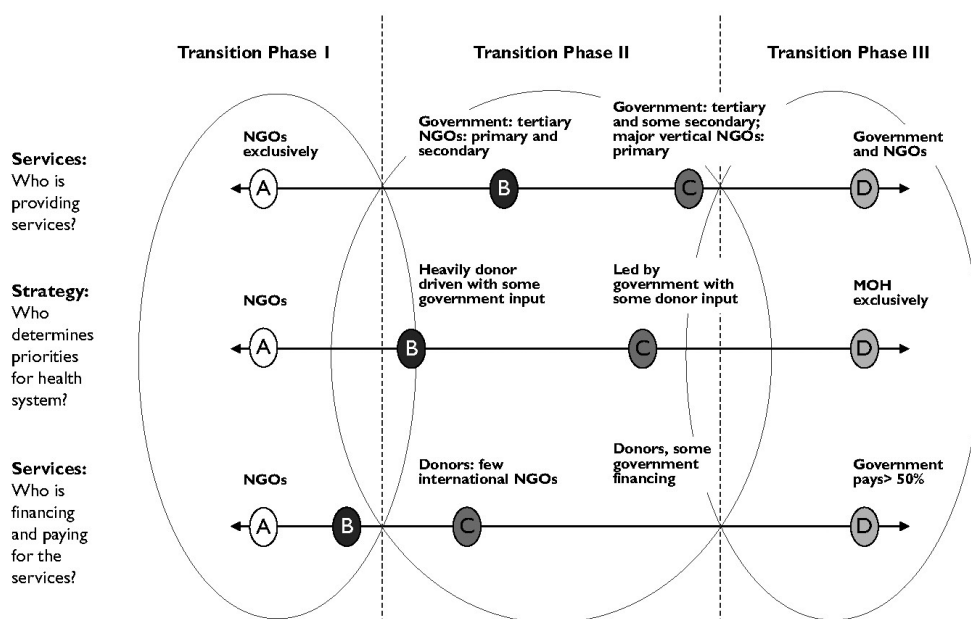
## **Essential principles for health system strengthening in fragile states**

The precursor to action in fragile states is to recognise that each state is unique—what has worked in one place cannot necessarily be applied in new situations. The characteristics of fragile states can serve as a starting point for analysis: it is useful to consider states as occupying points along a continuum for each element of fragility and to remember that states may move in and out of fragility. Health must be considered in the context of the bigger picture, which includes re-establishing the rule of law in some settings and meeting other basic needs (such as food, sanitation, security, shelter and water). 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. Thus health care is an important element that states can use to demonstrate their effectiveness and to establish their legitimacy.

**Moving fragile states toward development.** To transition from relief to development, countries must move through a number of stages—relief, rehabilitation, reconstruction, and development—across several critical areas (service delivery, setting the agenda, and financing). As countries emerge from conflict during the early post-conflict period, NGOs generally provide most of the services and are financed by international assistance. Over time, as government gains the capacity to set priorities, ensure the delivery of services, and manage funds, the public sector takes over these responsibilities.

It is important to understand that the transition from relief to development exists along a continuum. It is not a discrete situation in which a fragile state is completely in the relief stage or not in that stage at all. Rather, there is a spectrum from the least relief—a totally devastated state such as Haiti in 2010—to the maximum degree of development—a country that is ready to continue development on its own and to leave the ranks of the most fragile and poorest states. Figure 1 depicts how this progression might occur across the three transition phases. These stages do not follow a linear progression, however, in which one stage needs to be finished before the next one can start.

**Figure 1** Continuum of transition stages in the development of a health system in a fragile state



**Notes:**

- Country A: severe fragility.
- Country B: emerging fragile state.
- Country C: maturing fragile state.
- Country D: 'fully graduated' fragile state.

**Phasing in interventions.** Saving lives is the first priority in fragile states, and interventions must be chosen and sequenced to save the greatest number of lives over time. For example, one strategy might be to begin by addressing the most easily preventable diseases and deaths. In a humanitarian emergency, there is often no clear transition from crisis to development. Rather, relief work and development need to occur simultaneously. The experiences of many countries demonstrate that this is feasible. In 2005, for instance, the European Commission’s Global Plan for the DRC, designed to deliver basic services at the level of the health zones and to strengthen stewardship and the health information system at the national level, used its PATS I and II programmes, implemented from 1992–2005, as a foundation and model for its further engagement.

These actions happen in phases (such as between one and six months), but they are not neat and discrete, and progress can be undone. The idea of a continuum provides a dynamic understanding of how health systems can progress and regress during the fragile period.

Table 1 shows the three phases of action, with specific interventions and timing for donors and host governments to consider.

**Table 1** Phases of interventions and typical timing

<p><b>Transition phase I: meeting urgent health needs (1–6 months)</b></p> <ul style="list-style-type: none"> <li>• Deliver immunisations.</li> <li>• Provide essential drugs and vaccines.</li> <li>• Focus on disease prevention, care and treatment.</li> <li>• Offer humanitarian assistance and care for internally-displaced persons and refugees.</li> </ul>
<p><b>Transition phase II: quick-impact and medium-term responses (6–18 months)</b></p> <ul style="list-style-type: none"> <li>• Improve pharmaceutical management and supply.</li> <li>• Maintain existing services while expanding the scope of services.</li> <li>• Create and renovate infrastructure.</li> <li>• Promote community participation.</li> <li>• Develop health sector policies and regulations.</li> <li>• Promote donor coordination.</li> <li>• Gather information on health status and the health sector.</li> <li>• Develop an integrated national health plan to coordinate donor and government activities centring on agreed national priorities.</li> <li>• Focus on identifying or providing predictable long-term funding for health system reconstruction and recurrent costs.</li> <li>• Transition health care management responsibilities from implementing partners to the government.</li> </ul>
<p><b>Transition phase III: longer-term health system strengthening responses (18 months–5 years)</b></p> <ul style="list-style-type: none"> <li>• Increase access to equitable basic health services.</li> <li>• Engage civil society in meeting the health needs of the population, especially for specific diseases, such as the human immunodeficiency virus (HIV).</li> <li>• Provide technical assistance to the MOH to build its capacity and develop a policy framework for the health sector.</li> <li>• Increase the government's capacity to make intermediate and long-term plans and to manage the health system.</li> <li>• Expand human resources for health by working with training institutions and on testing and certification systems.</li> <li>• Create hospital boards and local health committees to empower local communities.</li> <li>• Help develop sentinel surveillance and response systems to monitor diseases.</li> <li>• Address prevention and control of diseases such as HIV and AIDS, malaria and TB.</li> <li>• Encourage enhancement of the capacity of private-sector providers to meet health service needs while simultaneously strengthening the government's capacity to regulate the private sector.</li> <li>• Address issues related to the long-term sustainability of health services.</li> <li>• Build a comprehensive, coordinated health management information system and promote its use among all health-sector stakeholders.</li> </ul>

## Conclusion

Programmatic experience in countries that are undergoing a humanitarian crisis or recovering from conflict shows that, although each national situation is different, one can highlight several key points for government officials and health care professionals operating in fragile states. A key premise is that assistance for health care and other social sectors in fragile states is a humanitarian imperative and necessary to promote international and regional security.

To guide the governments of fragile states and health partners as they rebuild the health system, this study proposes a series of critical actions that have proven effective in other fragile states.

First, the series of actions begins with simple, lifesaving public health interventions and transition planning. Over time, the focus must shift to building government capacity to manage the system, extending care, and long-term planning and financing to support a sustainable and equitable health system.

Second, the three transition phases described in this paper are appropriate even in disasters such as the January 2010 earthquake in Haiti. Despite the urgent need for lifesaving health services, planning discussions can begin to consider how the foundations of a reformed health system can be laid after the near-total destruction of the rudimentary health system that existed before the disaster.

Third, effectively addressing health care needs in fragile states requires interlinked long- and short-term strategies and financing that contribute to rebuilding the health system. The authors propose that these strategies be developed in accordance with five principles:

- the development and planning of strategies to rebuild the health system require government involvement and ownership;
- strategies must be based on national priorities;
- strategies should promote the equitable provision of health care;
- strategies should build on the elements of the health system that functioned well prior to fragility; and
- appropriate indicators should be selected and periodically monitored to track progress in meeting long- and short-term objectives.

Fourth, since leadership capabilities often are decimated in fragile states, health system strengthening requires the development of leadership and management of the health system. This study recommends placing experts in health system development in these countries for extended periods, rather than having consultants make many short visits, so that they can mentor and work alongside the ministry's leadership as the health system is rebuilt.

Fifth, everyone working in a fragile state must possess a thorough understanding of its political, economic, social and security situation and issues. It is not possible to have a 'cookbook' of interventions, because each situation is different. A deep understanding of the context is vital to determine not only what interventions will help to improve health but also which ones will assist in building a state with good government. Each situation will require making trade-offs between carrying out the short-term interventions that produce rapid results and beginning to address longer-term health system strengthening.

Sixth, the challenges of rebuilding and strengthening health systems in fragile states are not unique, compared to those that other developing countries face, but the scale of the problems and the obstacles that must be overcome frequently are much greater. Thus, a primary means of strengthening health systems and providing services in fragile states is to use available information to work with ministries to establish priorities. The dearth of information on the health sector in fragile states also may necessitate the development of new tools and creative approaches to distinguish health priorities for health planning purposes. Having clear priorities will help governments to reach populations whose health indicators are poor and for whom progress in improving health has been elusive for too long a time.

Seventh, with health serving as an entry point for addressing fragility issues, the objectives of the undertaking will determine the health interventions that are chosen.

For instance, if one of the aims is to support a government with good potential, then a health project will seek to use the state as the entry point. If the government is dysfunctional, an international organisation or agency, such as UNICEF or WHO, may serve as a substitute for government structures in order to provide humanitarian assistance and start the process of longer-term change. Community-based organisations also may serve as an entry point, although this option was not viable in Myanmar, where community structures are virtually nonexistent as part of state design.

Finally, because fragile states are difficult environments, governments and donors have to be creative in employing a mixture of approaches that respond to rapidly changing circumstances. That is, they must utilise a range of health interventions to take advantage of existing conditions and adapt quickly as conditions change. This need for flexibility is why local missions must have the authority to make decisions in the field and adjust their use of resources swiftly.

One should recognise that health services, by themselves, will not be sufficient to alter governments and improve the lives of the population. Rather, health services provided in combination with improved security, better opportunities for livelihoods through economic enhancements, and positive changes that give people a greater say in their lives and communities will help to improve the legitimacy and effectiveness of fragile states. In other words, the health of a population is a necessary but not a sufficient condition for addressing the root causes of fragility. However, by strategically targeting health system strengthening interventions, one can lay the foundation for sustainable and responsive health systems.

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