WHY IS IT AN EMERGING ISSUE?

Huge gains have been made in global health over the past 20 years in reducing maternal and young child mortality and in reducing deaths from infectious diseases, but certain countries affected by fragility and conflict have not experienced dramatic improvements.

HEALTH SYSTEMS IN FRAGILE STATES (1)

The challenge of meeting health needs for the world's most vulnerable populations.

By Nigel Pearson

****This is the first part of two briefs looking at the delivery of health care in states affected by conflict and fragility.***

Millennium Development Goals (MDGs) will not be met in most of the countries often referred to as *fragile states* (1), where a sixth of the world's population lives but where mortality remains very high and life expectancy low.

By 2015 it is estimated half of those in extreme poverty will be living in fragile states (2).There is a correlation between state fragility and health service coverage, with The Global Fund for example noting that 'fragile states' perform less well on access to treatment with antiretroviral therapies, and diagnosis and detection of tuberculosis. The global malaria burden, as with many other infectious diseases, is increasingly concentrated in these states (3).

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** This is the first part of two briefs looking at the delivery of health care in states affected by conflict and fragility. This first brief provides a conceptual approach to health systems in these countries. The second brief proposes solutions for reinforcing systems, ways of overcoming the challenges inherent in these environments.*

HEALTH SYSTEMS AND STATE BUILDING

Armed conflict, poverty and weak institutions are features of states experiencing fragility. They tend not to be able to provide adequate security, lack will and capacity to meet the needs of their populations, and lack inclusive policies for minorities and marginalised peoples. This weakens the legitimacy of central government with citizens. Elites dominate politics and may control resources.

'Fragile states' often have fragile health systems. The challenge in these states is how to strengthen health systems in ways that will impact on the principal causes of morbidity and mortality and improve poverty indicators while at the same time contribute to greater sustainability, stability and state legitimacy.

INTERVENTIONS BY INTERNATIONAL AGENCIES

International agencies are becoming more aware that even an emergency intervention during a conflict can profoundly affect relationships and capacities on the ground, and can either create dependency or promote sustainability.

International NGOs become part of the political economy, with their resources enabling them to quickly deliver services but at the same time attracting staff away from other health facilities or creating a challenge to sustainability when they suddenly pull out.

While investing on the *supply-side* in human resources, and strengthening procurement systems and quality service delivery, they also have opportunities to stimulate *demand-side* processes that increase utilisation of health services and coverage rates, improve accountability (4) and involve citizens in service provision. By encouraging local participation, working with community health facility committees, or women's groups, they may promote local democratic models that help to raise awareness about the right of citizens to health.

USE OF THE TERM 'FRAGILE STATES'

The term *fragile states* has been used in reference to an ill-defined list of 40 to 60 very diverse countries.

The term comes from the indices used to measure fragility, stability and sustainability in the world's states, of which the most authoritative is The Fund for Peace's *Fragile States Index*.

While these stability/fragility scales, based on qualitative research and quantifiable indicators, help to analyse to the challenges a country faces, the term *fragile state* is not always helpful as it is too ill defined, labelling too broad a group of very varying countries and its use is not welcomed in any country referred to in this way.

See: http://ffp.statesindex.org/rankings-2014.

OECD DEFINITION OF FRAGILITY AND RESILIENCE

"A fragile region or state has weak capacity to carry out basic governance functions, and lacks the ability to develop mutually constructive relations with society.

Fragile states are also more vulnerable to internal or external shocks such as economic crises or natural disasters.

More resilient states exhibit the capacity and legitimacy of governing a population and its territory.

They can manage and adapt to changing social needs and expectations, shifts in elite and other political agreements, and growing institutional complexity.

Fragility and resilience should be seen as shifting points along a spectrum".

OECD. 2013.

Health programmes affect the interaction between citizen, service provider and policy maker. Well-designed interventions can build up institutions, local governance and sub-national health system capacity as well as supporting public reasoning and the formation of values, and may contribute to political agency. They should reinforce the role of health authorities in setting policy, and in standardising and monitoring performance (5), and aim to strengthen state capacity as much at district as at provincial and national levels.

This health centre in eastern DRC was built by both community and international NGO working together.

Photo Credit: N. Pearson

The responsiveness of governments to citizens in delivering quality health services may strengthen the trust that citizens have for their government (6). But before being able to improve the health system or influence these processes, it is important to gain an accurate picture of the existing system.

DIAGNOSIS – HOW DOES THE HEALTH SYSTEM FUNCTION?

Development agencies should consider collaborating with national governments and/or regional authorities to conduct in-depth assessments of the current health systems in 'fragile states'. An excellent guide to *analyzing disrupted health sectors* is provided by the manual with this name, available on website of the World Health Organisation (7).

The New Deal for Engagement in Fragile States encourages agencies to collaborate on country joint risk and fragility assessments. Similar joint health system assessments would look at capacity and expose weaknesses in key health system components.[1]

Assessments should also examine the *political health*

A NEW DEAL FOR STATES

The *New Deal for Engagement in Fragile States* was developed through the forum of the *International Dialogue for Peacebuilding and Statebuilding*, which brings together states experiencing conflict and fragility with international partners.

The *New Deal* was endorsed at the High Level Forum on Aid Effectiveness in Busan, Korea, in November 2011. Countries set their own paths for transitioning out of fragility, involving an assessment and a compact to implement one vision.

Peacebuilding and statebuilding goals are adopted to enable progress towards Millenium Development Goals, and commitments made for reform and transparency.

See: http://www.newdeal4peace.org/

[1] To date, five out of seven pilot New Deal countries have conducted a fragility assessment. One critique suggests that country-led pathways out of fragility have been dominated by technical processes but with insufficient political dialogue and involvement of civil society. Hughes J. et al. (2014). Implementing the New Deal for fragile states.

HEALTH SYSTEM

A country's health system is the organisation of people, resources and institutions that deliver health services to meet the needs of a population that include both medical care and public health programmes.

WHO defines the goals of a health system as being good health for citizens, with responsiveness to their expectations, and fair means of funding health care costs.

WHO no longer publishes a ranking of countries' health systems, but rather a broader table of comparative health statistics that include indicators relating to numbers of health professionals, levels of health financing and health inequities, life expectancy and mortality rates.

Countries that have high levels of fragility often have very poor capacity for collecting these indicators, making comparisons difficult.

Good health system delivery can bring improved health status and lower mortality of a population, and contribute to poverty reduction and sustained economic and social development.

However, the fragility within many countries is often characterised by poorly performing health systems which do not deliver the benefits that would in turn further contribute to stability.

economy, and map the *health society*, including the effectiveness of service providers and vested interests, and the interrelation of state, community, private and external actors. Informal institutions that contribute in unconventional ways to the sector may be identified, with open-mindedness maintained in analysing how elements of public authority are created, often 'bottom-up', through 'complex bargaining between state and society actors' (8).

Detailed assessments will allow differentiated, tailor-made rather than standardised approaches in countries experiencing fragility. The information from these country-specific assessments can be used to guide *Annual Work Plans* (AWP) led by Ministries of Health that help to bring coherence across the system and provide indicators in each sub-sector for *Joint Annual Reviews* (JAR) that provide a progress update on a country's health system.

The following are some of the questions that need to be looked at to enable effective planning:

- How strong is government leadership and how effective are central and local governance arrangements? Are citizens represented and do all service providers participate in planning? Is health planning linked to poverty reduction strategies?
- What is the quality of citizen representation and participation, and accountability to citizens within the system? Are demand-side processes as well supported as supply-side delivery?
- What are the interactions between state, citizen, civil society, the private sector and service providers? What makes up the health society?
- How is the health system financed? What distortions exist in funding? What sub-sectors are neglected? Is there a published national health account?
- What mechanisms are in place to promote financial transparency and accountability?
- What norms of human resources for health (HRH) are in place?
- What coordination is there in procurement and supply-chain management (PSM) centrally and in regions?

THE SIX COMPONENTS

WHO refers to the **six building blocks of a health system** as: governance, financing, the health workforce, medicines and health products, health information and statistics, and service delivery.

Investing in and improving the effectiveness of these six components are vital in the process of making universal health coverage available to a population.

What is sometimes overlooked when analysing health systems is the *dynamics* of how citizens engage with the system and how different service providers (state, community, private) interact in fragile settings.

In reality there may be parallel systems competing for clients that are poorly coordinated and regulated. Data may not be available from many of the providers. The central state may only have information from state, and not community or private providers and only in certain regions of a country.

Analysts tend to pay a lot of attention to *supply-side* service provision and less so to vital *demand-side* processes that contribute to uptake, accountability, quality and sustainability of health services.

- How well developed is the national health information system (HIS) and are reliable data available?
- How well is service delivery understood and mapped? Where are the geographical gaps, what groups in society are not being reached with services? How can health equity be improved by fairer coverage of health services? How harmonised is delivery at health district and regional level? How well coordinated and regulated are service providers?

A CONCEPTUAL APPROACH TO ADDRESSING FRAGILITY

While designing strong technical health components of interventions is important, the underlying fragility of the health system also needs to be addressed. A detailed assessment (see *diagnosis,* above) will describe the weaknesses and strengths in the system, as well as the capacities of different actors.

Conceptual models are helpful to guide any planned interventions in addressing the weaknesses in building on the strengths. The following diagrammes (which can be adapted at central, provincial and district levels) compare service delivery within fragile and sustainable systems.

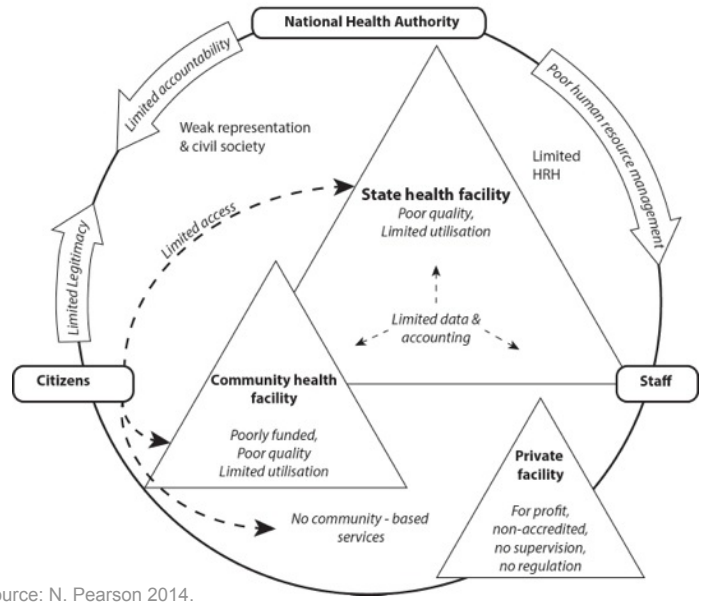
In the *fragile model*, there are parallel service providers (with some private providers outside any 'system'), and poor policy-setting, regulation and supervision by the national health authority.

There is a lack of investment in *human resources for health* (HRH), limited data and accounting from health facilities to authorities, to health staff or to citizens.

Citizens have poor access to poor quality services, with few community-based services and little participation or empowerment.

Citizens consequently accord little

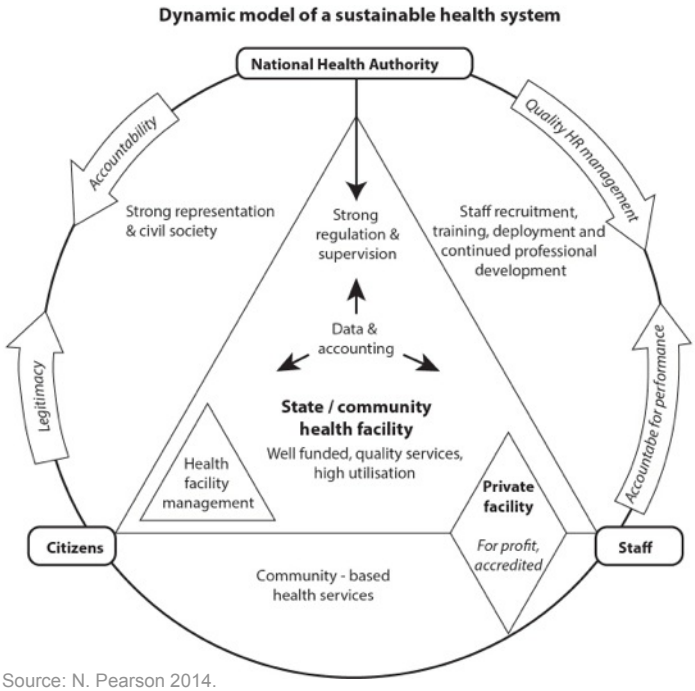
Dynamic model of a fragile health system



Source: N. Pearson 2014.
Graphics: Daniel Rous

legitimacy to the state with regard to service provision.

In the *sustainable model*, the national health authority provides a firm policy framework, and strong regulation, oversight and supervision.



Source: N. Pearson 2014.
Graphics: Daniel Rous

Human resources for health (HRH) are well developed, with coherent investment in staff recruitment, training, deployment and retention. The health workers are in turn accountable to authorities and citizens for delivering high quality services.

Health facilities have shared ownership between state and communities, with citizens empowered in leadership via health facility management committees and receiving reports on data and accounting for resources.

Financing is diversified, with inputs by authorities at central, regional and district levels, by other local government mechanisms, donors, the private sector, civil society, and with some direct inputs by citizens.

Greater accountability towards citizens comes from authorities. This potentially enhances the legitimacy accorded to the state by citizens, who themselves become players in this bottom-up state-community model. Private facilities are brought within regulation frameworks, and may at times operate within state/community facilities[2]. Voluntary accreditation schemes encourage improved peer performance in the private sector. Community-based services improve access and utilisation of health facilities and health-seeking behaviour at home.

[2] For an example of this, see the private pharmacies social franchise network model operated by MoH partner PSI in Somaliland: http://hcsshare.org/index.php/tools

Interventions by national health authorities and international agencies can be designed around models that build accountability, legitimacy and sustainability into the health system. Weak authorities can be strengthened by reinforcing service delivery to create a 'centripetal sense of belonging and shared meaning that endows them with resilience' (9).

The model will differ in every country, and may need to be adapted in each province or district, and will be designed based on the findings of the health system and political economy assessments.

Agencies will want to plan investments over many years, staying engaged so that they use leverage to encourage more national tax revenues to be assigned to the health sector (10) and to influence the nature of the developing health society[3] within state and communities.

CONCLUSION

This kind of conceptual thinking can be used, adapted, in any state. Agencies working to support governments and local providers may be less concerned with how a state is classified comparatively in terms of fragility and more interested in understanding how the country's health system functions (see *diagnosis*, above).

A country does not want to label itself 'fragile' but rather wishes to identify gaps and areas of weakness within the health system and find ways to address these effectively. This can be done by developing mechanisms that achieve results in areas with reduced access due to conflict or increased demand caused by recurrent natural hazards such as drought.

International agencies should differentiate and tailor their approach to the specificities of each context rather than addressing 40 to 60 countries deemed to be 'fragile' in the

[3] The term *health society* here refers to the combination of civil society, private and state health actors, and local and international NGO and faith-based organisations that are providing health services and their interrelation with the citizens who are accessing and contributing to services.

same way, where possible following an agenda set by the country.

The states themselves will hopefully want, and have the capacity, to set policy for the health sector as part of a broader compact for transition around which partners can contribute.

Some countries with conflict and increased operational risks may require higher investments for achieving impact and will need targeted sub-sector support in areas such as procurement and supply chains, financial management and human resource management, as well as for specific disease-control programmes.

Directors of Somaliland Ministry of Health working with UN and other international agencies on a joint assessment. Somaliland, 2014.

Photo credit: N. Pearson

Potential solutions for investing in health systems are discussed in the *Emerging Issue Brief on Health Systems in Fragile States, Part 2*.

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