UNITED STATES INSTITUTE OF PEACE www.usip.org

SPECIAL REPORT

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Health in Postconflict and Fragile States

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Summary

- The populations of states experiencing severe instability or unable to meet the basic functions of governance—referred to as fragile states—as well as those embroiled in conflict make up one-sixth of the world's population and suffer from far poorer health than their counterparts in other states at comparable stages of development.

- During many armed conflicts, health facilities and health workers come under attack, and infrastructure is often destroyed, inducing health workers to leave and undermining management capacity, thus further depleting health system competence to meet basic needs.

- Evidence is emerging that effective and equitable health services may be a central contributor to state legitimacy.

- All too often, health interventions in fragile and conflict-affected states are limited to humanitarian relief, which does not advance either health systems development or state legitimacy.

- Two decades of experience in development of health systems in fragile and conflict-affected states have shown a need to address weaknesses in policy, leadership, management capacity, human resources for health, supplies, service delivery, and data collection and evaluation through World Health Organization's (WHO) building blocks for health services.

- The military's record of engagement in civilian health systems development is poor, and its efforts to use health interventions to promote stability have not proven fruitful. Its most appropriate role in civilian health in fragile and conflict-affected states is to provide or support health services in highly insecure areas.

- Donors have not made health systems development in such states a priority in global health programs. Investments are often seen as politically or financially risky, and as having lower potential payoffs. Given the poor health indicators in these states, however, health development in fragile and conflict-affected states should be a higher priority.

- Donors need to confront directly whether the goal of health development is stabilization or population health.

- Research is warranted on the relationships between health and armed conflict and between health development and state building.

Introduction

The role of health in development and aid policy in conflict-affected and fragile states remains a conundrum. Evidence is increasing that conflict and fragility have a devastating impact on health. At the same time, knowledge on how to construct effective and sustainable health systems in these states through local leadership and donor commitment is expanding. Yet, except in countries of strategic or political interest to donors, such as Afghanistan, Iraq, or the Balkans, the level of donor investment in these states remains low even as global health spending has dramatically increased. Moreover, the policy animating these investments is murky, a mixture of health goals and political objectives relating to stabilization and counter-terrorism. Whether health investments can and should advance those political goals remains highly contested. At the same time, the conventional distinction between emergency health interventions and humanitarian relief on the one hand and health development on the other, although reflected in funding streams, often makes little sense on the ground. Conflict and fragility tend to be protracted, but health systems development can often proceed even before peace and stability are established. Further, fragility or conflict, and its attendant impacts on health, may well affect one or more regions of the country rather than its entirety.

War, Fragility, and Health

No consensus has yet been reached on a definition of a fragile or postconflict state. Generally, though, a fragile state is considered "unable to perform basic functions [such as] maintaining security, enabling economic development, and ensuring the essential needs of the population are met."[1] They are "characterized by weak policies, institutions, and governance."[2] These states are not just poor or corrupt; they are understood as incapable of accomplishing basic functions including providing effective core services such as education, transportation, state financing and administration, justice, and health. Some states experience fragility as a result of a political crisis while others are fragile for decades and intermittently erupt into violent conflict. Conflict-affected states are easier to identify, though organizations that track conflicts use varied definitions of conflict based on indicators such as number of casualties or extent of fighting. The distinction between conflict and postconflict status is imprecise because some conflicts become chronic, and displaced persons and refugees remain in camps or otherwise without permanent settlement for decades. In other states, a formal end to a conflict is replaced by high levels of continuing violence and instability, sometimes including renewal of war. An estimated one-sixth of the world's population live in fragile or conflict-affected states.[3]

Health Indicators in Fragile and Postconflict States

However defined, states characterized as fragile or conflict-affected tend to have far worse population health indicators than states at comparable levels of development and show less progress on achieving the Millennium Development Goals. Vulnerable groups—which include women, children, refugees, the elderly, and the mentally ill—in such states are generally affected the most. Poor indicators are likely a product of inadequate governance and service development, disruptions of health and determinants of health like clean water and sanitation, destruction of infrastructure, flight of health workers, or a combination of these and other factors.

In considering the impact of armed conflict on health, it is often difficult to identify exact causes of death and ill health, because indicators depend on a host of factors that include the size, intensity, and chronicity of the conflict, the state of existing infrastructure, and the extent of destruction of infrastructure, among others. Many of the reports of the relationship between armed conflict and health are based on small observational or survey-based studies and often do not include correlations with levels of fighting or other relevant factors. It can be said with some confidence, though, that in most conflicts the greatest impacts on civilian morbidity and mortality are indirect, and nonviolent deaths far outnumber violent ones.[4] A study reviewing World Health survey data estimated that 378,000 nonviolent war-related deaths occurred annually from 1985 to 1994 (a range of 156,000 to 614,000).[5] In Darfur, 87 percent of excess civilian deaths between 2003 and 2008 were nonviolent.[6]

These deaths are typically a result of increases in infectious disease from destruction of infrastructure, decline of preventive measures like vaccinations and access to clean water, and shortages of medication and supplies for treatment. The poorest countries, with low baseline health service capacity, and even more decreased capacity after a conflict, have the highest ratios of noncombat-related deaths.[7]

Some analysts have challenged the assertion that significantly increased civilian deaths are associated with armed conflict. The 2010 Human Security Report argues that "nationwide mortality rates actually fall during most wars" primarily because local conflicts do not dramatically alter the general trend in improvement of health indicators worldwide. It states that "of the 52 countries that experienced war in the period from 1970 to 2008, only 8 countries (or 15 percent) experienced any increase in the under-five mortality ratios during wartime."[8] More recent studies, however, question this analysis. They show that health impacts of armed conflict tend to be concentrated in particular regions or be a product of targeting identifiable demographic groups that national level studies may not reveal. In a background paper to its 2011 World Development Report, World Bank analysts showed that though conflict can dramatically affect the health of populations directly involved in the violence, the entire country may not suffer equally.[9] Their comparison of mortality rates between provincial regions and the nation as a whole within conflict settings reveals that provincial data is often dramatically different from national aggregates. Particularly in conflicts that are more locally focused, targeted groups within populations may be more significantly affected than the population as a whole.[10] Another critique of the Human Security Report approach is that under-five mortality may not be an appropriate indicator of the impact of conflict on health because it shows long-term trends, and may decline or increase in the months and years after a conflict rather than during it.

Moreover, even if declining in conflict regions, in sub-Saharan Africa more than 60 percent of under-five deaths occur in areas of chronically unstable governance, and of these almost two-thirds are preventable. The data also indicate that the highest potential for excess deaths among children is in low-level conflicts in poor countries.

Finally, national statistics may be misleading, given the nature of statistical reporting systems and the disruptions caused by conflicts. Because national reporting may select for populations in more secure environments where assessments are easier, proportionally fewer conflict-affected populations may be surveyed.[11] Regional surveys in Kenya, Congo, Somalia, and Ethiopia, for instance, show that some areas are less surveyed than others, creating black holes that could skew national data. Additionally, generalizations from available country statistics may not fully assess breakdown in health-care delivery, in particular isolated populations such as internally displaced persons and refugees, who usually have worse health status and may live in camps outside the reach of demographic country data. Comparing data with expected outcomes, as the Global Burden of Disease Project has done,

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and to neighboring areas, might reveal more about health impacts than passive demographic health survey data.[12]

Increased morbidity is also significantly associated with conflict, though here, too, the relationships are complex. Mental health impacts of war are often severe.[13] For other conditions, especially in chronic, low-level conflicts, morbidity may not follow expected patterns. A study in Nepal has shown that of nineteen Millennium Development health indicators, sixteen actually improved during the time of the Maoist insurgency from 1996 to 2006. One factor that could have influenced this finding is that the Maoists attempted to support the communities where they operated; another is that indicators were among the worst in Asia at the time the insurgency started.[14]

More sophisticated methods of determining the precise relationship of fragility, conflict, and health, including assessments within regions, are needed. What existing studies demonstrate, though, is that these relationships are hardly incidental, and the public health community is obligated to collaborate on information collection and sharing to better understand the health terrain of modern fragile states.

Attacks on Health Facilities, Personnel, and Patients

Security of health-care infrastructure and health-care personnel are at high risk from attack, interference, or obstruction during armed conflict.

Security of health-care infrastructure and health-care personnel are at high risk from attack, interference, or obstruction during armed conflict. These assaults violate international law and can undermine the ability of institutions and personnel to carry out their missions, stimulate migration of health workers away from places in need, and limit access of populations to critically needed health-care services. Infringements of security can come in various forms. At the most basic level, health workers, hospitals, and patients come under direct attack, through shelling, bombing, or shooting, and by interference with water supply or electricity, or obstruction of access. Facilities may also be taken over by security forces or armed groups for military purposes. Health workers are targeted for killing, kidnapping, or assault, or subjected by security forces to arrest, detention, and prosecution for having provided impartial medical care to combatants or others associated with a side opposed to those forces. Ambulances may be denied travel through checkpoints or shot at. Further, Red Cross insignia may be misused for unauthorized purposes.[15] The assaults not only bring about immediate casualties, but deprive a population of a key health resource, such as a hospital, clinic, or health worker, over the long term.

The experience of Liberia during its civil war indicates how hospitals, rather than being safe havens for the ill, can become targets. Phebe Hospital, where Dr. Walter Gwenigale, Liberia's current minister of health and social welfare, worked at the time, was attacked and looted in September 1994 and again in 2002. Much of the equipment and most of the drugs were looted. Staff members were threatened and fled. Although many health workers returned in the years following the end of the civil war, the already sparse staff diminished in size, leading to fewer health consultations and less access to treatment for the community. A recent study by the International Committee of the Red Cross in sixteen countries revealed 655 violent events against health-care personnel and patients, including killing, wounding, and kidnappings, as well as denial of access to facilities and destruction of infrastructure, in just two and a half years.[16]

Research is scant on the specific impacts of assaults on health worker migration and on access to health services, but given health worker shortages in fragile states and inadequate infrastructure, the losses would be likely to be heavily felt. In Iraq, where health worker flight as a result of targeted attacks has been studied, the departures were significant, and health services suffer from lack of qualified staff.[17]

Intimidation of health workers through demands to restrict services to individuals associated with a particular faction or group may also impede access to care. In Nepal, the

government required health-care practitioners to report any patients who were possible Maoists; in Kosovo, Kosovar Albanian physicians were arrested and prosecuted for allegedly providing health-care services to members of the Kosovo Liberation Army. In so doing, the government was attacking the oaths of physicians to provide unbiased and equal care to all. These attacks, as clear ethical and human rights violations, require a greater commitment from the international community for documentation, prevention, and accountability.

As U.S. assistant secretary of state for democracy, human rights, and labor Michael Posner explained, international humanitarian law requires states to take measures to protect patients and medical personnel. Agencies responsible for reporting on and demanding compliance with human rights laws, however, have devoted too few resources and too little priority to reporting and use of diplomatic tools to secure compliance with international obligations. The need for protection remains urgent. Posner acknowledged that governments and human rights organizations need to do more to use diplomacy to seek compliance and report on and condemn violations. In a step toward enhanced reporting, the U.S. Department of State has committed to including incidents of attacks on health personnel, facilities, and patients in its annual country reports on human rights practices.[18]

Health, State Building, Stability, and Governance

Stabilization and peacebuilding in fragile and postconflict states have become major features of international policy and foreign assistance. A number of factors contribute to this increased attention. First is a high rate of conflict recidivism, given that 31 percent of conflicts restart within ten years of concluding.[19] Second, conflict has a destructive impact on population health and well-being. Third, concerns exist about the potential for local conflicts to evolve into regional ones and for poorly governed states to become a breeding ground for terrorist groups. One key unanswered question in furthering such policies is the role health programs can play in advancing state building and stability.[20]

In the long term, stronger health systems can improve the health of the population, in turn leading to greater productivity and economic growth, less violence, and state stability. Evidence indicates that improved health services can increase trust in government and thus modestly contribute to reinforcement of the authority and legitimacy of the state through developing human capital, providing quality health services, promoting citizen oversight of health programs, generating fiscal reform, and creating monitoring mechanisms.[21] A study by RTI International of Iraqi citizens has shown, however, that the relationship between providing services and trust in the state is not always linear. The researchers found a U-shaped correlation between community satisfaction with water services and willingness to pay for these services, which can be seen as a proxy for trust in the state. At the lowest end of satisfaction, people are willing to pay almost anything just to get a service, and that willingness doesn't reflect faith in the government; when they are very satisfied, citizens may trust the government and also be willing to pay for these services. Between these extremes, when some services are provided but are poor quality, citizens are not as willing to pay.[22]

Different communities and populations also have different expectations of what the government should provide. What Iraqis historically have expected from government service may be very different from what is expected in Europe or sub-Saharan Africa. Moreover, health is often low on the list of people's priorities when compared with security, jobs, a fair justice system, and education; health services are not considered significant for many people until they become sick. Furthermore, health services are a necessary but hardly sufficient feature of the government; if the government does not provide other basic services such as education, transportation, water, electricity, and justice, it may not be seen as legitimate or gain strength despite hefty investments in health.

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The evidence does suggest, however, that equity in services may be a more powerful predictor of confidence in government than the general sufficiency of services. Health services are often not equally distributed within countries and are often particularly weak for rural or scattered populations.[23] These inequities may, in some circumstances, motivate conflict among different groups. Service inequalities often predate the conflict and continue after it. It is possible that to the extent to which health services become more equitable, they may reinforce state legitimacy, and thus can play a role in reducing the likelihood that conflict will resume. This question, though, has not been the subject of rigorous study.

Responding to these inequities is not simply a matter of institutionalizing equity in service delivery; it also requires the contribution and collaboration of numerous communities and reinforcement of the authority of the state to perform its role. Both the Guatemala Peace Accords of 1996 and the South Sudan Comprehensive Peace Agreement of 2005 had language setting out the health and education obligations of the government.[24] However, in weak states without stable infrastructure, articulating the obligation does not ensure the capacity to deliver these services. UN agencies or other nonstate actors may be required to help provide services. The specific mechanisms of this assistance can either hinder or help state legitimacy.

Donors can affect the ability of a ministry of health to use health services to advance state legitimacy. The most important action, of course, is to provide funding for the equitable development of health services. In doing so, however, they need to reinforce the authority and leadership of the host government, which may be the most critical factor in developing an effective health system. They can advance legitimacy by helping build the capacity of the ministry and refraining from touting their own contributions. For instance, donors can pool funds and permit the ministry of health to contract services to nongovernmental organizations. The ministry must develop capacity to develop a plan for services, manage the contracts, and ensure financial accountability for the funds.[25]

Evidence is only anecdotal, however, of the impacts of health programs on stabilization, which differs from legitimacy and state building in that it principally concerns establishing and maintaining security.[26] The theoretical mechanisms by which stability through health interventions could occur are complicated by the nuances of each state's history of conflict and ethnic or other composition. Metrics need to be established to measure potential impacts of health development on stabilization. The paucity of evidence on the relationship between health and stability, however, should not be a basis to refrain from investing in health. Instead of looking for tangible stability dividends from those investments, policymakers can take the broader view that health investments are essential to a healthy population, long-term development, and state legitimacy.

At the same time, efforts to meet immediate humanitarian needs should take the impacts NGO actions have on service provisions into account. NGO interventions that are not coordinated with national government can have negative effects on state legitimacy and be potentially destabilizing. Similarly, failure to include government actors in planning and executing humanitarian response to advance health system development can be a missed opportunity to build state capacity and legitimacy. In South Sudan, for example, despite generous humanitarian relief in the face of only 25 percent of the population's having access to primary health services, the United States has not prioritized health interventions except those that have immediate impact, such as malaria control.

Policymakers have asked whether investing in a particular health program can advance stability. This is a political question. The alternative and essential question is whether health investments can improve people's lives and well-being. The answer is clearly yes. At the same time, peace and stability promote and protect health, so investments in security also have health benefits.

Health Reconstruction: Lessons Learned and Challenges

Fragile states vary greatly in history, governance, sources of conflict, and health indicators, but by definition lack legitimacy and effective service administration. Because of weaknesses in stewardship, accountability, delivery of essential services, resource management, financing, or security, these states are often unable to fulfill a basic function, to organize a system of health services.[27] The health sector often suffers from weakness in infrastructure, health supplies, and adequately trained staff—which may stem from existing inadequacy, attacks during conflict, neglect, or all three—as well as deficiencies in resources and administration, data collection, and management. They are also characterized by gross inequities in access and quality. Natural disasters that strike these states exacerbate the challenges. The health service delivery system, including coordination and oversight of service systems, is often in disarray, leaving communities without proper access to medical care, particularly outside urban areas.

In many cases, these deficiencies also mean that the government is not participating in medical care, leaving nongovernmental and private actors to operate an uncoordinated and poorly directed delivery system that leads to inequitable service delivery (and possibly fuels further conflict). Without a coordinating mechanism, many clinics may open in some regions but none in others, leaving communities alienated from health services. Similarly, without government stewardship of appropriate information collection, the health system often operates with little up-to-date information on current health status, epidemics, locations of health facilities, and other important indicators. Finally, in the absence of a capable ministry, fragile states often lack the management capacities that allow for developing budgets, tracking expenditures, assessing workloads, managing human resources, and carrying out disease surveillance.[28]

To meet these daunting challenges, reconstruction efforts should be based on the World Health Organization's six health system building blocks—leadership and governance; health services; health information; human resources; financing; and access to essential medicines, vaccines and technologies—as the core structural components of a state's health system.[29] Moreover, key questions about sequencing must be tailored to the capacity, security situation, and state of health in each state.

Giorgio Cometto, Gyuri Fritsche, and Egbert Sondorp cite the need for "sustained investment in assessment and planning of recovery activities; building of procurement capacity early in the recovery process; support for funding instruments that can disburse resources rapidly; and streamlining the governance structures and procedures adopted by health recovery financing mechanisms and adapting them to the local context."[30] The process requires strong local leadership, as has been demonstrated in Liberia. Donors and those who provide technical assistance should work with the national government directly, as well as with NGOs and other actors, to build capacity. It is critical to meet short-term health needs of the population even as the arduous work of health workforce development, management capacity building, and planning take place. Often a balance must be struck between short- and long-term needs.

The experience of health services development in a wide variety of fragile and conflict-affected states has yielded important lessons in strategies to strengthen national government capacity in key areas of need. Several high-impact interventions have proved useful. Developing a plan and strategy for a package of basic health services based on local information collection and survey data can be a productive starting point around which to align health priorities. Assisting with identifying the needs of the nation and creating this package has been a successful basis for future rebuilding in Afghanistan and Liberia.[31]

In Afghanistan, the World Bank, the EU, and USAID funded the model. Each took responsibility for one of three regions where they provided financial and technical assistance to the

ministry on capacity building, including contract management regarding services offered by NGOs to implement the package. By 2005, a new basic package of health services capable of expanding to a broader level of interventions among both rural and urban populations was developed. The success of this package and its capability to transition to more ministerial leadership is a key lesson in aligning priorities and strengthening government management of the health sector.

The specific model of strengthening basic services will vary depending on health, geography, capacity, and political circumstances. In 2002, Afghanistan's new Ministry of Public Health made a vital if controversial decision approving a basic package of health that focused on reducing maternal and child mortality rather than a larger package that included mental health or disability. Despite pressure for more comprehensive coverage, the need to set priorities and to place particular focus on it in rural rather than urban areas was clear. In Liberia, rebuilding rural health clinics after the war was considered the priority, including promoting equity between urban and rural areas. In Somalia, where central government barely exists, NGOs developed relationships with health "ministries" among the factions to promote service development.

The need to adjust to local circumstances is also illustrated by the role of the ministry of health. Although the ministry is generally the key player, in some circumstances its leadership is impossible because of corruption, instability, weakness, or political opposition. In bureaucratic and hierarchical ministerial systems, a slow central government can weaken health resources in already vulnerable areas. In such circumstances, creating a decentralized model that can communicate effectively with the central government to realize both national and local goals should be a priority.

Another vital priority in most fragile states is to develop human resources in health, where severe shortages generally exist even apart from the impact of war. The first requirement is having enough trained health workers to appropriately treat and manage the health needs of the population. Standardizing skills and certifications pose challenges in locations where many health workers may not have had access to adequate training and technologies. Educating nurses, technologists, and physicians is a long-term (and expensive) necessity, and many states have expanded the role of community health workers as one way to alleviate urgent shortages. In Southern Sudan, where human resources for health have been all but nonexistent, and many areas are so vast and remote as to be impossible to reach regularly, the strategy to improve health worker shortages includes a leadership training program combined with service expansion. Acquiring a steady supply of essential medications and equipment is also vital for health workers to adequately manage patients.

Identifying costs and aligning with donors and government resources to ensure the availability of long-term funding is vital for the health system to recover and rebuild.

For all of these priorities, identifying costs and aligning with donors and government resources to ensure the availability of long-term funding is vital for the health system to recover and rebuild. Although coordinating donors and managing national programming in the context of local autonomy in creating health schemes will be difficult for nascent governments and stakeholders, creating a sustainable investment strategy is the lynchpin of health system reconstruction.

Promoting transparency, participation, respect for human rights, and accountability from all parties is a final priority for all fragile states to improve their health systems system. In Liberia, President Ellen Sirleaf Johnson has made accountability a priority for the government, as well as for donors and private organizations. By taking on this responsibility, the government has shown that it can successfully and transparently manage finances and has also become the principal recipient of major aid contributions. Participation must take place at all levels, from community engagement in planning and oversight to involvement of women in leadership in service design and implementation, consistent with the principles of UN Security Council Resolution 1325 and its successors.

In particular, integrating women into planning as well as training must be a priority to address the chronic discrimination against women and subordination of their health needs that exists in many fragile states. Taking that approach can both change social and power relationships and improve health. In Afghanistan, where women have been at the forefront of health services development, the first basic package of health services focused on child and maternal health. Despite massive illiteracy among women, the ministry and partners were able to train women to provide birth control to an otherwise inaccessible population. Despite their volunteer status, with motivation and need, the attrition rate of these community health workers has been low.

The challenges of supporting health systems development in postconflict and fragile states are especially severe when corruption, political repression, lack of willingness to lead, or severe instability are present. In these circumstances, health services must be developed through local officials, NGOs, and civil society. There are some models on which to build. In Somalia, in response to the lack of a legitimate governing presence, NGOs have been taking the lead in the development of the health system. With the assistance of the Global Fund to fight AIDS, Tuberculosis, and Malaria, for example, World Vision International and other NGOs have been able to increase capacity despite the lack of a stable government ministry to ally with. Working with all factions, the groups have spent more than eight years supporting sixty-four tuberculosis (TB) management units and detecting more than 38,000 TB cases. By training health workers, improving health facilities and laboratories, and building a national TB strategy in the country, they have identified gaps and begun to fill them. This capacity building has potential to contribute to a sustainable health system backed by a legitimate government in the future. Ignoring health in badly governed states like Zimbabwe, where the regime allowed what had been a strongly functioning health system to deteriorate, only leads to crisis and further suffering.

Military involvement in civilian health systems development in conflict-affected and postconflict states remains problematic. As Ambassador Donald Steinberg, deputy director of USAID, pointed out, it is highly unlikely that future armed conflicts will resemble Afghanistan or Iraq, and therefore reliance on lessons from Afghanistan and Iraq may not be productive. It is worth noting, however, that little evidence suggests that health interventions as part of counterinsurgency strategy have achieved either strategic or sustainable civilian health benefits, especially compared with the initiatives of the Ministry of Public Health and its donors.[32] The reasons have to do with the incompatibility of military approaches to the task with the principles of health systems development, for example, short time frames for action, lack of connection between long-term goals and programs, lack of follow-up, and use of metrics for success based on money spent.

In regions beyond Iraq and Afghanistan, the military is involved in providing civilian health programs toward "winning hearts and minds" where the United States has a strategic goal of countering extremism. In such instances, concerns arise about the impact of unstable and inequitable funding decisions that can result in confusion and resentment by recipients about the purposes of the aid. Addressing the question of the role of the military in civilian health development programs, which has arisen frequently over the past decade, will be vital to the continuing discussions of health in fragile and conflict-affected states.

Ultimately, working with unstable, fragile, and postconflict states poses a number of challenges that require experience and thoughtful planning. By prioritizing the principles of improving management capacity, developing long-term commitments, promoting transparency and accountability, and using information systems to create a set of priorities to align around, fragile states can begin to recover from their devastated infrastructure, poor administration, and weak legitimacy.

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Health Investments in Fragile and Conflict-Affected States

Global health assistance has rapidly expanded in recent years to more than $20 billion globally. Health investments in fragile and conflict-affected states have not received a proportionate share of global health resources based on population needs, with the exception of Afghanistan and Iraq, where U.S. and European donors have major strategic and military interests.[33] Of the thirty-four countries and regions the President's Emergency Plan for AIDS Relief (PEPFAR) program serves, fewer than five fall under most definitions of fragile or postconflict states.[34] Indeed, the relationship between the under-five mortality rate in African states, which are highest in badly governed states, and the level of development assistance to those states is inverse.

Several factors have influenced the aid strategies of donors for fragile states where they lack strategic interests. Donors may consider investment in fragile states to be politically and financially risky. They may further perceive that aid in these states has less payoff than aid to states with more stable governance. Indeed, countries with better policies and better institutions may be able to more effectively use aid for community health. However, this approach leaves fragile states under aided and "receiving less aid per capita than their poverty, populations, and CPIA scores would justify."[35] Currently, evidence suggests that these factors cause aid in fragile states to be twice as unpredictable compared with other low-income countries, potentially damaging growth and service delivery.

Emerging experience indicates, however, that well-measured aid to fragile states can be considerably more effective in improving growth than aid to other low-income countries. Because fragile states may be particularly impoverished and lacking resources, with appropriate safeguards their initial ability to absorb aid and use it effectively could be higher than more stable countries. Aid practice, however, has not characteristically followed this model. Instead, aid is often disbursed for humanitarian emergencies during a conflict and tends to diminish dramatically when the conflict winds down. This approach often results in a transitional funding gap between humanitarian aid allocation immediately following a crisis and development funding that comes only years later.[36] The funding gap can jeopardize service provision as well as the ability to develop stable and sustainable health services.

Moreover, there is a mismatch between organization of health assistance and programs. The traditional distinction between humanitarian and development aid is often unresponsive to real needs. Some humanitarian crises extend for years, and emergency assistance can span decades, using resources to meet immediate needs but ignoring opportunities to build systems and address problems of governance in health. In Southern Sudan, humanitarian health assistance continued for twenty years but emphasis on development was minimal. The notion that such aid should not concern itself with development of a functioning health system makes little sense. Although donors are beginning to look for ways for humanitarian assistance to stimulate or reinforce longer-term development, by and large the two streams of funding have different goals, different legal requirements, and different measures of effectiveness. And though short-term results in humanitarian aid are understandably central, donors also resist making painful trade-offs between meeting short-term relief demands and promoting longer-term benefits. Decisions almost always lean toward short-term needs, even in circumstances where more lives could be saved in the longer term by concentrating on development.

Development strategies with humanitarian aid are possible. In the Democratic Republic of Congo, the humanitarian aid effort lacked a stable national government to work with. Instead, a fragmented but functional health zone system ran regional health systems. Health professionals were present, but too few of them. By working directly with local health zones and their local government administrators, humanitarian programs were able to function for an extended period as development programming expanded.

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Donors are also often understandably concerned with the repercussions of providing development assistance to corrupt or repressive states. It is vital to resolve these tensions. The answer to donor concerns is not to avoid health development assistance to fragile and conflict-affected states, but to develop mechanisms that can address corruption and lack of capacity. Weak civil administration, in particular, can devastate optimistic plans for government participation in aid, leading to fragmented and disorganized aid allocation and planning strategies as donors rely more heavily on nongovernmental organizations to provide services. Early research has suggested that an initial focus on technical and administrative assistance in a government committed to reform can assist greatly in long-term governance capacity.[37] Intensive technical support in Afghanistan, for example, has enabled its Ministry of Public Health to manage funds without the level of corruption that plagues other ministries, and to develop the technical competence to manage contracts with reasonable effectiveness. Where repression exists, it may be necessary to find alternative mechanisms for financing, participation and accountability.

Financing mechanisms themselves can be used to improve governing capacity while providing greater authority to governments. Liberia's experience in creating its national health plan and basic package of health services and administering donor contributions through a pool fund is instructive. The fund was created in 2008 in response to both the uncoordinated efforts of multiple donors, which had led to severe geographic inequities, and the desire of the government to exert greater control over development even though it lacked sophisticated administrative capacity.[38] The pool fund enabled donors to support government-established health service priorities and normalize health worker staffing and salaries among numerous providers, yet be assured of financial accountability. In the years since the pool fund was established, Liberia has successfully established a rigorous facility accreditation process that, combined with major donor investment, has improved the number of functioning government health facilities from 36 percent in 2006 to 82 percent in 2008.

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Conclusions and Policy Recommendations

Health investments can contribute to state building and legitimacy, though the degree to which they do so remains uncertain; whether health can advance stability is unknown. The knowledge base must be expanded. If donors choose to make stability rather than human needs a priority, they should support research to learn whether and how health interventions can contribute to stability. The research is essential for wise and productive investments especially if stabilization and security are deemed objectives of health assistance.

Research is also needed to better understand the health consequences of armed conflict, including the extent of morbidity and mortality and factors that influence them. These potentially include contextual factors—such as intensity, chronicity, geography, regional patterns, preconflict state of health services, history, and culture—that may affect the extent of morbidity and mortality in fragile states and particular armed conflicts.

Knowledge must also be developed to inform strategies that afford greater protection to and preservation of health functions during armed conflict. Greater understanding is needed about the motives of perpetrators, incentives and training that might influence their decision making, and successful prevention strategies. The impacts of assaults—including effects on morbidity, mortality, systems capacity and health worker migration (from attacks, from threats, and from more general insecurity)—deserve scholarly attention. Data on attacks on health-care facilities, personnel, and patients must be collected comprehensively; studies on reasons for and impacts of assaults must be initiated; and evaluations of prevention programs must be undertaken.

Finally, research is also required to better understand how to assist fragile states in building effective health systems. This includes more robust exploration of the experience of, and lessons that can be derived from, health systems development in fragile and conflict-affected states, including at the subnational level and in badly governed states. In addition, at least four key questions have received too little attention. The first is how to structure aid programs in poorly governed states so as to develop health systems without supporting corrupt or repressive governments. The second is how to restructure humanitarian aid programs so that long-term emergency funding supports health systems development. The third is how to meet short-term health needs while developing a coherent system. The fourth is whether decentralization is an effective strategy either in addressing local grievances or compensating for a weak state. Agencies responsible for disaster response should conduct a thorough review of how humanitarian aid programs can contribute to development of health systems, especially in protracted or chronic conflicts. Evaluations should assess both structuring a transition from relief to development and integrating systems development into emergency programs.

Despite these unanswered questions, there is now enough knowledge about mechanisms and the impacts of postconflict health reconstruction to justify a shift in priorities in global health funding. Those who live in conflict-affected and fragile states can and should receive their fair share of funding under major multilateral and bilateral funding programs. Indeed, questions about whether and how investments in health promote legitimacy and stability are to some extent distractions. That health systems development can contribute significantly to the preservation of life and well-being of people in such states is reason enough to invest resources there. Global health funding programs should afford greater priority to fragile and conflict-affected states based on their highly disproportionate morbidity and mortality for their stage of development, especially among children, and the recognized connection between an effective service system and long-term state legitimacy.

The existence of corrupt, ineffective, or repressive governance—although it poses serious challenges—should not be an absolute barrier to supporting health systems development. In such situations, policies and programs need to be developed to support alternative means of health systems development. Withholding proven health and systems interventions is unacceptable.

In all fragile and conflict-affected states, programs should follow general principles of systems development, preferably through leadership by the ministry of health. Adhering to standards of equity and nondiscrimination is essential, and respect for human rights principles regarding process will increase legitimacy and quality. The latter includes engagement of women in the planning and oversight process and community participation in governance, oversight, and accountability for health services. Women should also be included in programs to train community health workers to provide lifesaving interventions, particularly for infants and young children.

The role of the military in advancing health in fragile and conflict-affected states requires close attention. The military can play a major role in disaster relief, support for military health systems, disease surveillance and research, and provision of emergency health services in highly insecure areas. It should not, however, be assigned responsibilities to contribute to civilian health systems development, nor to use health as a short-term stability intervention. When the military carries out other health activities, it should be aware of the potential linkages and tensions between the assistance it might provide and strengthening health systems.

Acknowledgments

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