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HEALTH PROGRAMMING FOR REBUILDING STATES A BRIEFING PAPER

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HEALTH PROGRAMMING FOR REBUILDING STATES

A Briefing Paper

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U.S. Agency for International Development
Bureau for Global Health
Office of Health, Infectious
Diseases, and Nutrition
Ronald Reagan Building
1300 Pennsylvania Ave., NW
Washington, DC 20523
Tel: (202) 712-0000
Email: globalhealth@phnip.com
www.usaid.gov/our_work/global_health

BASICS
4245 N. Fairfax Dr., Suite 850
Arlington, VA 22203
Tel: (703) 312-6800
Fax: (703) 312-6900
Email: basics@basics.org
www.basics.org

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Abbreviations

BASICS	Basic Support for Institutionalizing Child Survival
BPHS	basic package of health services
OECD/DAC	Organisation for Economic Co-operation and Development/Development Assistance Committee
NGO	nongovernmental organization
USAID	United States Agency for International Development

Executive Summary

This paper discusses three specific potential health sector programming contributions for United States Agency for International Development (USAID) field missions in countries that fall into the “rebuilding” category of the new foreign assistance framework (formerly “fragile states”):

- Support to the development of a strong policy framework, typified by a basic package of health services (BPHS)
- Provision of long-term technical assistance to the central and especially the intermediate levels of a health system
- Development of a system of health care provision that is characterized by public sector management of private sector implementation.

Examples of each strategy and a more in-depth discussion of the issues are available in other BASICS (Basic Support for Institutionalizing Child Survival) publications in this series.

Introduction

This briefing paper presents a number of topics for consideration by USAID field missions, especially those involved in the design of health sector programs in countries that fall into the rebuilding category of the new foreign assistance framework (formerly “fragile states”). The ideas presented are derived from the BASICS project’s long experience working in humanitarian and post-conflict environments, most recently in conjunction with the Organisation for Economic Co-operation and Development/Development Assistance Committee (OECD/DAC) on analyses of health service delivery in fragile states and with the USAID Bureau for Global Health. Specifically, BASICS staff conducted field visits in Afghanistan, the Democratic Republic of Congo, Southern Sudan, and Uganda, where extensive discussions were held with a wide variety of bilateral and multilateral donors, nongovernmental organizations (NGOs) and other service provision organizations, ministry of health officials, and USAID mission staff. On the basis of this experience, BASICS produced a number of review papers and case studies (see annex).

This paper is not a primer. It cannot give advice to health officers on effectively implementing USAID-funded health programs in a particular country as contexts vary considerably from one country to the next. Among the variables at play are the mix of donors and their specific interests, the host government’s priorities, approaches, and, indeed, their level of acceptance of donor proposals, and the number and characteristics of the service providers available to contribute to the reconstruction and rehabilitation of a primary health care system. On the other hand, context is not everything; we can derive lessons from the all-too-many experiences that have accumulated in rebuilding countries in the past few years.

Foreign Assistance—From Charity to Security

A significant shift has occurred recently in the orientation of U.S. foreign assistance policy. Not long ago, U.S. social sector programs, including health, were undertaken primarily for humanitarian reasons. These included attaining lower morbidity and mortality rates by providing better access to and greater utilization of higher quality health services. Today, political considerations play a much larger role. Foreign assistance to rebuilding countries is directed to a much greater and more clearly stated degree toward issues such as avoiding a return to conflict; this goal is to be achieved principally by developing and promoting the legitimacy of

fledgling governments and increasing their ability to govern effectively. While we are not offering a judgment on this change of emphasis, we are acknowledging its importance. Indeed, the intellectual rationale behind the U.S. foreign assistance policy shift was rarely challenged in all the countries visited.

The Critical Interaction between Security and Health

Considerable support for the shift in foreign policy strategy can be derived from a nationwide study in the Democratic Republic of Congo. This study showed that, even though violence was not a significant proximate cause of death, overall mortality rates and child mortality rates were significantly elevated in health zones with reported incidents of armed conflict, compared to those where peace reigned. This and similar examples have led to the conclusion that a major cause of mortality is not always disease. Other factors, some of which can be directly addressed by current U.S. foreign assistance policy, should also be taken into consideration.

Two final thoughts are worth emphasizing. First, it is important to understand that, while there is evidence that a peaceful environment and good governance can contribute to the recovery of a battered and dysfunctional health system, there is little (if any) documentation attesting to the health sector's ability to contribute to attaining the political objectives that have become a more prominent part of U.S. foreign assistance. This has potentially important implications for developing monitoring and evaluation indicators for health programs in rebuilding countries. Existing congressional earmarks (and more local indicators) for health programs tend to be traditionally formulated—that is, they seek to measure vaccination coverage levels, the proportion of children receiving vitamin A, under-five mortality rates, and the like. It may serve the health sector well in the near term to begin to include indicators in health programs that show whether or not the provision of improved health services contributes to a population's willingness to view its new government more favorably. Based on the adage, *what gets measured gets done*, incorporating such indicators into new health programs may result in those programs being able to make a substantive and measurable contribution to the political process.

Second, strengthening health programs is now and will always be a primarily humanitarian endeavor, and any attempt to put health in the same programming category as conflict resolution, arms reduction, or the re-integration of ex-combatants (to give just a few examples) will likely, and correctly, be seen as a superficial attempt to squeeze a square peg into a round hole. Even though it might be possible, health programming does not have to be justified on the basis of its contribution to economic development, as has been suggested many times. Neither does health programming need to be justified on the basis of political stability, which is the current overriding theme for U.S. foreign policy. Achieving an improved health status for a population is a desirable end in and of itself, and it is not only a step on the way to the attainment of other, more political, goals. Investing in people is an important component of the new U.S. foreign assistance framework, and it should be supported to the maximum extent possible. In addition, it can also be argued that equitable health systems and the services they offer are core social institutions that are part and parcel of democratic systems of governance. A citizen's ability to successfully make claims on a functioning health system is concrete evidence of good governance and a politically stable environment.

Donor Harmonization

Donor harmonization—the basis of the OECD/DAC approach—is the first important principle to respect in programming social services delivery in post-conflict countries. Even though different

donors may have different strategies and even different foreign assistance objectives, donor efforts will fail unless there is some attempt to coordinate with one another and with the host government.

Obviously, one challenge in developing a harmonized approach from the donor side is the weak policy framework that is a characteristic of rebuilding states. The starting point for all donors, and for the government, should be therefore to establish a common vision of the rebuilt health system structure and of the services that it should offer. In Afghanistan, the Democratic Republic of the Congo, and Southern Sudan, among others, the basic package of health services (BPHS)—prepared as a joint effort by all working or planning to work in the health sector—has proven to be an extremely valuable tool. In most instances, the BPHS specifies the physical characteristics of health facilities, their distribution on a population basis, their staffing patterns, and their specific public health interventions. Health financing policies can also be included. Importantly, indicators for measuring progress toward the achievement of a stronger health system are also drafted and adopted. Of course, BPHS implementation strategies have varied widely, but public health priorities, objectives, and targets remain constant and are respected by all. Support for BPHS development is an excellent initiative and worthwhile investment.

USAID missions have been remiss in their failure to communicate their intentions to other donors and to host governments in a timely and effective manner (see BASICS case studies of Democratic Republic of the Congo and Southern Sudan). Instead of drastically modifying the content of their health sector programs, several missions implemented the fragile states strategy by changing their geographic focus. In other words, although USAID signaled to both the host government and other donors that the agency would be working in certain areas, when USAID sought to conform to the new strategy, the agency shifted its efforts to those areas where it had determined there was the greatest risk of a resumption of armed conflict. In neither of the two countries cited was there disagreement with the logic behind this decision, but there was great disappointment—even anger—expressed toward the missions for not undertaking these changes in concert with others working in the health sector. As a result, other donors had to scramble to satisfy the governments' reasonable request that large, politically important parts of their countries that had been receiving USAID assistance would not be left without support.

Technical Assistance

Closely related to donor harmonization are issues of central level policy formulation and translation of policy into programs at intermediate levels of the health system. Other BASICS reports in this series have noted that in most developing countries and in rebuilding states in particular, a great deal of attention has been paid appropriately to the development of a national-level ministry of health and to the service delivery level, that is, from the district-level down. In every situation that BASICS has studied or observed, the intermediate layers of the system—at the province, state, or county level—were relatively neglected. In some, such as in post-conflict Cambodia, health system managers at this level who were receiving no assistance actually became obstacles to health program implementation.

For this reason, we have recommended in some situations that USAID give strong consideration to providing long-term technical assistance in the form of advisors to ministries of health at both the central and intermediate levels. Centrally, USAID and its contractors have particular expertise in a number of areas that can contribute to the overall coordination of a young health system—in the development of health information systems, for example, or the institution of efficient procurement and distribution systems for drugs and other commodities. At

the intermediate level, where management systems are generally weak, technical assistance in management, monitoring, and supervision (among other functions) would help those responsible to oversee BPHS implementation and to make them part of the solution, not part of the problem.

Peace Dividend

For a fledgling government to establish its legitimacy, it is important to show the populace that *their government* is hard at work fulfilling its functions. These functions include providing security, protecting the borders, growing the economy, and providing essential services such as health and education. As important as it is as a building block, people cannot see, and often do not appreciate, the development of a strong policy framework.

If the most visible sign of a functioning education system is schools, the corollary in health are clinics and hospitals. Although classic life-saving interventions (such as measles vaccination campaigns, widespread distribution of malaria bed nets, and other programs that form the core of emergency relief operations) should never be abandoned, these programs do not depend on fully functional health systems nor, in many instances, are they the highest priority for a war-weary population. While never abandoning the activities that are the hallmarks of humanitarian action, USAID health programs in rebuilding states should give strong consideration to supporting the construction and rehabilitation of primary health care facilities (not tertiary care hospitals that only serve the needs of the wealthy or those living in urban areas), as is being done in Afghanistan and Iraq. Strong consideration should also be given to the provision of adequate staff and the procurement and regular distribution of drugs and supplies. By doing so, both humanitarian and political objectives can be met, and a fledgling government can become more legitimate in the eyes of a wary population.

The window of opportunity for visible action in the health sector is relatively narrow, and nascent governments often feel pressured to show early results. Developing health services to the point where the population's health status improves measurably is a medium- to long-term process, but the actions suggested above can be done within a reasonable time frame. Because the objective of these actions is to enhance the government's legitimacy—where this is appropriate—"branding" of new and improved health structures should be done in a way that ensures that the needs of both the host government and the donor(s) can be satisfied.

Equity and Quality: Highly Desirable, But Are They Necessary?

Two important issues arise in relation to the realization of the peace dividend.

The first is equity, an essential feature of public health programs. However, in rebuilding states and especially those where the prevention of renewed conflict is an important consideration, equity may not have highest priority. Consider a situation analogous to that of Southern Sudan, where the only vestiges of a health system that remained after decades of conflict were in garrison towns and areas along the border with Khartoum-controlled Sudan. In an attempt to consolidate the peace agreement, recently USAID determined that these were exactly the areas at greatest risk for a renewal of hostilities and, for this reason, the agency is concentrating its efforts here. Health services in these areas are rudimentary at best, but are nevertheless relatively more advanced than in other, more stable areas. The best strategy would be to work in all areas of need (again, one of the values of donor harmonization is that areas can be covered without duplication or omission), but the political imperatives of U.S. foreign assistance suggest—not necessarily wrongly—that paying less attention to the equitable distribution of

health services in the short term increases the probability of achieving and sustaining equity in the longer term.

Quality of care is the second issue to consider. Nicely built clinics stocked with medicine, but staffed with incompetent personnel, will obviously do nothing for reducing morbidity and mortality levels in the population. Yet developing a qualified health staff is a longer-term undertaking, inconsistent with the government's short-term needs. This is a difficult problem to resolve, and it will require considerable attention by the government and donor community alike. There are ways of overcoming this and other similar problems that fledgling governments frequently face. Working closely with the private sector, especially the not-for-profit private sector, has been shown to be particularly effective.

Service Delivery and Public–Private Partnerships

In most cases, human resources are sorely lacking in rebuilding countries. Individuals with marketable skills have an easier time migrating and, insofar as health professionals are concerned, the numbers of people required to fulfill health needs are simply not found in country. Some solutions to this problem have been proposed. Various ways of attracting doctors and nurses home from the diaspora have been tried, at least on a short-term basis, but, usually because of inadequate incentives, most strategies have not been consistently successful after an early surge of nationalistic pride has subsided.

For this reason, it is important for ministries of health to understand early on that traditional notions of their role might have to be discarded. In all post-conflict countries studied, the public sector simply did not have the manpower to be able to provide the needed services. Instead, ministries of health have to concentrate on the formulation of public health policies (see above) and the management (but not necessarily the implementation) of health service delivery. Some ministries of health have difficulty accepting this restriction on their customary role, while others recognize and even embrace it.

The obvious solution to this dilemma is to make service delivery the private sector's responsibility. There are many different ways of managing the relationship between public and private sector. For example, in Afghanistan, Cambodia, the Democratic Republic of the Congo, and Southern Sudan, the World Bank and other donors have championed a system of performance-based contracting between ministries of health and NGOs. In Afghanistan, with initial World Bank assistance and ongoing assistance from the semi-detached Grants and Contracts Management Unit, the Ministry of Health decided that, of the many NGOs that had been working in the country during the emergency period, it would contract with one to implement the BPHS in each province. After a competitive bidding process, the ministry awarded a lump-sum contract to an NGO, often the lead of a consortium of international and Afghan organizations, to achieve pre-determined performance goals. If the NGO's work was satisfactorily accomplished, it received a substantial bonus. If its work fell far behind schedule, its contract was terminated and a new NGO sought for that province. To date, the system is working reasonably well. Although there are limitations, performance-based contracting is worth considering—having observed it since its inception, the USAID mission in Afghanistan has recently moved towards joining this scheme.

Of course, there are less-controlled ways of health sector programming, such as the sector wide approach-like process of giving money directly to the government, but USAID generally insists on a higher level of accountability than these allow. On the other hand, the traditional USAID system of hiring of a contractor to oversee the issuance of grants to NGOs or to implement

programs directly has been called a “state avoidance strategy” by some. Again, to a considerable extent, staying clear of the slow and unclear decision-making processes and plodding bureaucratic procedures that characterize a rebuilding ministry of health makes sense if humanitarian concerns are of the highest priority. This is why the USAID Office of Foreign Disaster Assistance, for example, has developed mechanisms that are different from those of the development side of USAID; these mechanisms allow for rapid, more unfettered action. Put simply, more help can be provided to more people more quickly if sufficient funding is provided directly to the NGOs that are working at the population level rather than provided to government authorities. But, in the long run, assistance to the development of efficient and effective government systems may have a longer-lasting impact by reducing the risk of a resumption of armed conflict, as discussed above.

The crux of the problem for programming in rebuilding states is thus: Is it better to try to improve the population’s health status as quickly as possible by bypassing early, unclear, and cumbersome government mechanisms, or is it better to work with government (in this case, with the ministry of health) to strengthen health sector governance by trying to ensure adherence to clear, effective public health strategies? In a state of emergency, where there is no functioning government, the answer is clear. However, donors, NGOs, and emerging governments have not done a good job of negotiating the transition from emergency to development. Considerable attention should be accorded to this issue.

Conclusion

This paper attempts to briefly outline some principal findings and observations that have been made in regard to the delivery of health services in so-called fragile or rebuilding states. In these countries, both the provision of humanitarian assistance to war-weary populations and political assistance to new governments that are attempting to establish legitimacy and effective governance are U.S. foreign assistance objectives. This two-track approach creates problems for health officers. The importance of harmonizing donor assistance cannot be overemphasized—if new governments are paralyzed by competing, and often conflicting, donor programs, no one program’s objectives can be achieved.

Annex

Other publications in the USAID/BASICS fragile states series—

Newbrander, William. 2006. ***Arrested Development in Fragile States: Opportunities and Guidance for USAID Health Programming***. Arlington, Va., USA: Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).

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Waldman, Ron. 2006. ***Health in Fragile States, Country Case Study: Democratic Republic of the Congo***. Arlington, Virginia, USA: Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).

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Rietveld, Cornelis Willem, and Ron Waldman. 2006. ***Health in Fragile States, Country Case Study: Southern Sudan***. Arlington, Virginia, USA: Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).