

The Role of the Health Sector in Wider State-Building

A discussion paper



Health & Fragile States Network



Save the Children
UK

The Role of the Health Sector in Wider State-Building

A discussion paper

The Health and Fragile States Network was created in October 2007 by a group of interested agencies and donors. The aim is to stimulate the policy and research agenda around how to best organise and finance health services in these environments. The Network is aimed at health professionals and others interested in health issues and health system strengthening in fragile states. For more information see www.healthandfragilestates.org

Save the Children is the world's independent children's rights organisation. We're outraged that millions of children are still denied proper healthcare, food, education and protection and we're determined to change that.

This report was written by Nigel Pearson.

Published by
Save the Children UK
1 St John's Lane
London EC1M 4AR
UK
+44 (0)20 7012 6400
savethechildren.org.uk

First published 2010

© The Save the Children Fund 2010

The Save the Children Fund is a charity registered in England and Wales (213890) and Scotland (SC039570). Registered Company No. 178159

This publication is copyright, but may be reproduced by any method without fee or prior permission for teaching purposes, but not for resale. For copying in any other circumstances, prior written permission must be obtained from the publisher, and a fee may be payable.

Cover photo: Health workers at the Kroo Bay health clinic, Freetown, Sierra Leone. (Photo: Anna Kari)

Typeset by Grasshopper Design Company
Printed by Stephen Austin & Sons Ltd

Contents

Foreword	v
Acknowledgements	vi
Abbreviations	vii
Executive summary	viii
1 Introduction	1
2 Concepts and definitions	2
2.1 Fragility and resilience	2
2.2 State-building	3
2.3 State-building and nation-building	4
3 Health sector impact on wider state-building	5
Key domains	5
3.1 Development of human capital	5
3.2 Quality health service delivery	7
3.3 Promoting citizen voice, accountability and inclusiveness	11
3.4 Monitoring and advocacy	14
3.5 Global initiatives	17
3.6 Resource allocation	19
Particular contexts	21
3.7 Stabilisation	21
3.8 Decentralisation	23
4 Conclusion	24
References	25
Endnotes	28

Foreword

The primary concern of the Health and Fragile States Network is as a global community to address the appalling health statistics in many fragile states. These states carry a disproportionate burden of maternal and child mortality and morbidity, and are furthest behind in reaching the health-related Millennium Development Goals (MDGs). Through its membership of policy-makers and practitioners working in or on the issues that relate to fragile states, the Network collates and disseminates evidence on appropriate and sometimes innovative ways to deliver health services in these contexts to address this burden. The contexts of these fragile states are diverse and often very challenging, posing unique challenges. Interventions need to improve health, but should not increase fragility, and there may be options to contribute to processes such as peace-building and state-building.

The idea that improved health service delivery may contribute to state-building, and thus to greater resilience of the state and its health system, is currently generating much discussion within the health sector and beyond. The idea is increasingly being debated by non-governmental organisations, academic institutions and development partners. It rests on the premise that affordable, good-quality healthcare, ideally with universal access and participation by civil society, would have a positive influence on the compact between a government and its citizens, eg, build trust and legitimacy, and would thus impact positively on state-building. At present, we have little evidence to conclude whether this premise holds true or whether

different ways of delivering healthcare impact differently on state-building processes, and the role that international aid can play in that process.

We have only just begun to unpack the complexities of the relationship between health and state-building. How do we get better answers? What are the right questions to ask? Where is more evidence needed? How can health professionals, political scientists and others find each other to take these discussions forward and, ultimately, come up with realistic recommendations for those working on the ground, often in difficult circumstances?

In 2008 the Health and Fragile States Network commissioned work on health and state-building (see www.healthandfragilestates.org). The Network is pleased to see that Save the Children UK took the initiative to commission another piece of work that looks at a number of key domains within the health sector where the link with state-building may become visible. The paper brings together a number of very interesting examples of where the paths of health and state-building may cross. While this paper will contribute to the debate, it also shows that much more work is needed in this area, in particular around generating the evidence base to address the question of the potential impact of health activities on wider state-building processes.

Egbert Sondorp,
Senior Lecturer, Public Health and Humanitarian Aid,
Health Policy Unit, London School of Hygiene and
Tropical Medicine

Acknowledgements

Many people have been consulted during the writing of this paper. The author would like to thank the following for their pertinent insights:

Olga Bornemisza, Nichola Cadge, Fiona Campbell, Ann Canavan, Steve Commins, Edda Costarelli, Jacob Hughes, Chris Lewis, Michael Markus, Maurizio Murro, Robin Nandy, Len Rubenstein, Mark Segal, Egbert Sondorp and Simon Wright.

This paper has been commissioned by Save the Children UK, working in collaboration with the

Health and Fragile States Network (HFSN) and it links to previously commissioned work by the HFSN. This paper has been supported by funding from Save the Children Italy.

This paper has been written with input from Save the Children UK and the Health and Fragile States Network. However, the opinions expressed in this paper are the author's and do not represent the policy of either Save the Children UK or of the Health and Fragile States Network.

Abbreviations

CBO	Community-based organisation
CPIA	Country Policy and Institution Assessment
CRED	Centre for Research on the Epidemiology of Disasters
CRISE	Centre for Research on Inequality, Human Security and Ethnicity
DAC	Development Assistance Committee
DFID	Department for International Development (UK)
DRC	Democratic Republic of Congo
ECHO	European Commission Humanitarian Office
EPHS	Essential Package of Health Services
GAVI	Global Alliance for Vaccines and Immunisations
GHI	Global health initiative
HFSN	Health and Fragile States Network
HRW	Human Rights Watch
HSR	Human Security Report
ICRC	International Committee of the Red Cross/Crescent
ICESCR	International Covenant on Economic, Social and Cultural Rights
(I)NGO	(International) Non-governmental organisation
IRC	International Rescue Committee
ISA	Independent Services Authority
LICUS	Low-income countries under stress (World Bank classification)
LRA	Lord's Resistance Army
MDG	Millennium Development Goal
MSF	Médecins sans Frontières
MOD	Ministry of Defence
MOH	Ministry of Health
NATO	North Atlantic Treaty Organization
NRC	Norwegian Refugee Council
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
PHC	Primary health care
RENAMO	Resistência Nacional Moçambicana
UNITAID	International Drug Purchasing Facility
TA	Technical assistance
THET	Tropical Health Education Trust
VDC	Village development committee

Executive summary

A sixth of the world's population is estimated to live in the 40 to 60 states that are considered to be fragile. Fragile states have low levels of legitimacy and poor capacity to deliver key functions such as maintaining security, enabling the market and delivering public services – for example, health. State-building is primarily an internal process whereby the social contract between the political elite and citizens is institutionalised, and as such it is context-specific to each state. State-building is becoming the prime framing agenda for donor foreign policy and investments in fragile states. Promoting the strengthening of the state–society relationship is fundamental to international engagement in state-building. State-building activities should start by degrees during crises, using flexible, context-specific strategies. Emerging norms in the conceptualisation of state-building and fragility are discussed in this paper. Terms such as stabilisation, it is suggested, are perhaps used too broadly, subsuming core state-building processes into them and creating confusion in the role of different sectors and actors.

There are many domains in which the health sector contributes to wider state-building. This paper highlights six of them. The paper also examines two particular contexts: decentralisation and stabilisation. Investing in quality service delivery and in the training and deployment of health workers is essential for strengthening health systems and at the same time has state-building properties, especially when promoted via a creative network of public and private partners. The role of ministries of health in standardising, regulating and monitoring performance of diverse partners becomes pre-eminent, but equally important are the role of

empowered communities in promoting sustainability and ownership, and the accountability of local government. Enhanced citizen engagement can contribute to reducing inequities and discrimination, and contribute to stability. The health sector has particular opportunities to give voice to marginalised groups such as women, the elderly or those with disabilities, and to bring them into processes of public reasoning and the formation of values, of recognising and realising their right to health, and potentially enhancing their political agency.

The sector also plays an (underdeveloped) role in establishing datasets and in monitoring trends in levels of disease, death and violence in fragile situations. There is potential for greater analysis by health professionals of the extent and causes of increased mortality and morbidity rates, and of both conflict and non-conflict violence (including sexual violence), witnessing the ways that a state uses or abuses its key functions and advocating for reduction strategies.

International health players advance international norms of quality healthcare and of the right to health. A 'double compact' comes into play as a state–international community relationship emerges, with expectations and responsibilities on both sides, that helps to create momentum for the fulfilment of minimal levels of access to healthcare. In striving to attain these expectations, the state gains some respectability with its citizens and with other states, and social justice becomes increasingly globalised. Finally, the health sector advocates for more resources to be brought in to meet essential healthcare needs, including resources

from increased regional and central tax revenues. If combined with calls for improved public fiscal management, including the monitoring of revenues by citizens, then state legitimacy may be advanced.

The paper concludes that health sector interventions, whether intended or not, always affect the interaction between citizen, service-provider and policy-maker, and therefore international partners should aim to reinforce,

and not undermine, state resilience through these interventions. Well-designed interventions can build up sub-national capacity and support democratic processes of public reasoning and consent-building. Ultimately, states will not become capable and accountable unless citizens are engaged in demand-side processes such as resource mobilisation and allocation, and in monitoring the performance of service-providers and state authorities.

I Introduction

Between 40 and 60 states are regarded as being 'fragile', and different indices are used for measuring fragility and its opposite, resilience, in all states. The governments of fragile states are characterised by having limited legitimacy and effectiveness. In the health sector they have been unable to ensure universal primary healthcare provision and will be unable to meet Millennium Development Goals (MDGs) such as significant reductions in under-5 and maternal mortality. The scale of devastation caused by the Haiti earthquake is an unfortunate reminder of the extreme poverty and weak state capacity¹ that leave more than a billion of the world's citizens vulnerable to natural hazards, disease, and political and economic shocks.

State-building is becoming the prime framing agenda for donor foreign policy and investment in fragile states. State-building is understood as being a continuous process of bringing about resilience, manifested by increased *legitimacy* and *effectiveness* (state willingness, capacity and accountability). The most significant determinant of long-term poverty and conflict reduction is increasing *resilience* of states, and thus one of the central objectives of international assistance should be to support the building of capable and accountable states (World Bank 2008) and make them more resilient in key areas such as legitimacy and capacity to deliver services, administer justice and provide security.

This paper examines ways in which the health sector contributes to wider state-building. It makes the connection in an iterative way rather than

presenting conclusive evidence, illustrated by examples that highlight the potential for an enhanced role. More research is needed into health sector activities in relation to state-building functions in specific countries in order to build up a body of evidence to *prove* impact. This paper provides a broad sweep over areas of interaction between the health sector and wider state-building in fragile states, focusing on the sub-national level where citizens and service-providers interact.

Drawing on examples of health interventions in states experiencing weak governance and degrees of fragility, the paper highlights six areas in which the health sector contributes to wider state-building processes. This is followed by looking at two contexts that each strongly affect, and that are influenced by, the health sector. It picks up on recommendations of previous articles commissioned by the HFSN that called for further examination of the way in which particularly decentralised and 'bottom-up' approaches in the health sector could contribute to the state–society contract and wider state-building (Eldon et al 2008, Ter Veen et al 2009). The current paper is the work of one author, but feedback has been given by HFSN members. It draws on an extensive literature review of articles pertinent to state-building from the health sector and other sectors. Some of the examples cited are known personally to the author, but new fieldwork was not conducted for this paper. The author developed some of the tools for the Somali health system that are mentioned.

2 Concepts and definitions

The terms *state-building* and *fragile states* have various meanings that reflect the assumptions of those who are making them, and which change as the lessons of contemporary state-building scenarios are taken into consideration. For many international agencies and national governments, the understanding of these concepts is still a 'work in progress'. Further confusion is created by the huge overlap in meaning of terms such as *state-building*, *peacemaking/peace-building*, *early recovery* and *stabilisation*. The following discussion aims to highlight emerging norms in the conceptualisation of state-building.

2.1 Fragility and resilience

A *stable* or *resilient state* is one that has political legitimacy, resulting from the capacity of a state to effectively perform key functions, including ensuring security for its citizens and enabling social welfare and a profitable market. Fragility arises from dysfunctional political processes that do not deliver an equilibrium between the expectations of state and citizen (OECD 2008). *Fragile states* have weak governance, policies and institutions (World Bank 2008) and are unable or unwilling to create the economic, social and political conditions in which the rights of the population can be realised. They include those states that are unable to secure their borders and in some cases to secure anywhere

outside the largest towns, that have dysfunctional markets that do not attract foreign investment, and that cannot provide services to the majority of the population. They are faced with economic stagnation, extreme poverty and violent conflict (Rosser 2006). Fragile states with conflict are often referred to as having a *complex emergency*.²

A sixth of the world's population of 6.5 billion is estimated to live in fragile states (OECD 2009a). The term *failed state* is also sometimes used to refer to a state that does not have a monopoly on the use of force and does not have the legitimacy to protect its borders, its citizens or itself (MOD 2009).

States have different degrees of stability and fragility. Although in most categorisations there are an estimated 40 to 60 'fragile' states, some of these will be resilient in certain domains, and more stable states may be prone to fragility. The recent credit crunch exposed fragility in many states previously regarded as being stable with unshakeable markets. Future shocks coming from financial meltdown, the peaking of oil supplies or the effects of global warming, conflict or natural hazards could potentially expose unpredicted weaknesses in more stable states. But the states currently regarded as being fragile are economically weak and vulnerable from chronic conflict, recurrent natural hazards and extreme poverty from which they are unable to recover.

2.2 State-building

A state can be seen as a ‘dynamic, citizen-oriented mechanism’ that establishes ‘a legitimate, social and political order’ (Ghani and Lockhart 2009). The term *state-building* refers to an essentially endogenous and dynamic process of the institutionalisation of the social contract (OECD 2008), which results from the legitimisation of a political elite through its capacity and willingness to govern effectively in key functions. This legitimacy comes about through:

- 1 the establishment of a political settlement
- 2 the state carrying out its ‘survival functions’ (security, rule of law and public finances)
- 3 fulfilling public expectations (of their entitlement to services, of sound economic management and of permitting voice and accountability via the media, free elections and wider citizen engagement) (DFID 2010a).

International engagement in state-building should focus on promoting the strengthening of the *state–society relationship* (OECD 2007, DFID 2010a), in recognition of the important role that civil society has to play.

International partners can contribute to building state *capacity* (enhancing the performance of government institutions) if there is existing state *legitimacy* (the legitimacy to govern conferred by citizens to political leaders, which is further reinforced as the state effectively performs key functions and gains the *authority* to govern). It is difficult for the international community to create this legitimacy where it does not exist, and or to ‘build’ states from the outside in. What they may be able to do is try to provide certain conditions that can *nurture* the possibility of legitimacy between citizen and state developing. That legitimacy cannot be imposed. Rather, international partners can ‘accompany and facilitate existing domestic processes, and leverage local capacity’ (Menocal 2009). State-building is *primarily* a political process

of creating legitimacy. *Capacity-building*, an aspect of state-building, is the process of creating policy, institutions and performance in different state functions. Some authors regard capacity-building as separate from state-building, others see it as an integral part.

The Institute of State Effectiveness provides a conceptual model of the state being built up around ten core functions (adapted from Ghani and Lockhart 2009):

Core ‘survival’ functions

- Monopoly on the means of violence (and capacity to secure borders)
- The rule of law
- Public finances (taxation)
- Public administration

Fulfilling public expectations

- Enabling the market
- Infrastructure services
- Human capital development
- Management of natural, industrial and intellectual assets

Relations

- Social contract (the relation between citizen and state that manages expectations around rights and duties), democracy
- International relations (and compact with international partners) and public borrowing

In this model, effective service delivery is consequent on stability and relies on good legislation, sources of income (from taxation), a flourishing market (both ensuring supplies and to some extent provision of services), core infrastructure (transport networks, communication, water and sanitation, health facility construction), a trained and effectively deployed workforce, and

sound management of assets. It is dependent on effective public administration. The social contract comes from the fulfilling of expectations that citizens have of the state and their capacity to engage with the state through democratic processes (and to chose preferred political representatives). A compact also develops with the international community as the state becomes more competent in fulfilling expectations held by the community of states relating to norms and standards of state behaviour and capacity. International partners have expectations of what level of service provision the state can ensure for its citizens (via the setting of policy, regulation, coordination, financing and contracting out), and guide the state with international norms. The health sector relies on a strong market for logistics and procurement. The sector also plays a role in defining expectations of the social contract. It can be influential in creating expectation about the state's capacity to collect revenues and spend it on social welfare, can influence the rule of law and can highlight abuses in the monopoly on violence.

The international community seeks to provide the conditions needed to nurture positive state development. In the World Bank/ LICUS strategy, the success of donor interventions to help 'turn around' fragile states depends on (Rosser 2006):

- the degree of donor engagement
- how well donors use their leverage
- the broader character of the political economy, especially the political context for economic reform
- how well donors aid the provision of basic social services, through supplementing weak central government delivery by strengthening multiple alternative channels.

To the above, others would add the importance of trying to reduce *social exclusion* as a means of decreasing state fragility (Stewart and Brown 2009) in order to make governments more representative and accountable to all citizens. It is at sub-national level that measures to increase social inclusion are most effectively implemented.

2.3 State-building and nation-building

These terms are often used interchangeably, but in this paper the term state-building is used when referring to building political legitimacy and capacity to fulfil key functions. Nation-building can be used abusively to manipulate people around a single *perceived* ethnic or religious identity to the exclusion of others who are not from the *perceived* group, or it can be used constructively to shape a common identity (DFID 2010a) that overcomes narrow prejudicial allegiances. In this context, nation-building can be an important component of state-building. Leadership has a strong influence in either manipulating a sense of narrowed identity³ around the illusion of a unique identity (Sen 2006) or helping people to jointly affirm common identities around a vision of shared citizenship. While the construction of a national identity is primarily an endogenous process, international actors can be influential in promoting a more inclusive identity. For example, NGOs (especially health NGOs) can promote transparent recruitment processes that employ staff who are representative of different ethnic, cultural, religious and gender identities.

3 Health sector impact on wider state-building

Key domains

1. Development of human capital
2. Quality health service delivery
3. Promoting citizen voice, accountability and inclusiveness
4. Monitoring and advocacy
5. Global initiatives
6. Resource allocation

Particular contexts

7. Stabilisation
8. Decentralisation

Key domains

Health practitioners have laid out clear strategies for priority interventions in making health systems effective and accountable (Newbrander 2007, WHO 2007 with its framework of six health system building blocks). Less clear are the effects of this health-system strengthening on wider state-building functions, and what other activities undertaken by the health sector impact on state legitimacy and accountability. Analysis of health systems in Sierra Leone and Nigeria showed that well-constructed, decentralised services (including healthcare) that involve greater citizen engagement and capacity to hold local politicians accountable can help to build confidence in state health services and suggests a wider impact on state-building in other sectors via capacity-building and citizen involvement in public life (Eldon et al 2008). Poverty reduction is another effect of health interventions that lessen conflict

risk, but the benefit has not yet been attributable to the health sector. Here, six domains⁴ are discussed in which the health sector relates to wider state-building processes. This is followed by looking at two contexts that each strongly affect, and are influenced by, the health sector. Decentralisation is a highly political process with huge implications on the administration and financing of the health sector. Stabilisation is primarily a security-driven process, relating very closely to peace-building and state-building.

3.1 Development of human capital

Among the key factors that drive successful transitions are the presence of strong leadership and management, and investment in human capital (Ghani and Lockhart 2009). Investing in a good-quality healthcare workforce is prerequisite to health-system strengthening and also has state-building

Development of human capital

Investing in a quality healthcare workforce not only strengthens the health system, but also builds the capacity of the state through investing in dynamic individuals who act as leaders for change within health services and government as well as being strong advocates in the private sector and the diaspora.

properties. These come from investing in dynamic individuals who can act as leaders for change working towards quality improvements in ministries of health and potentially other ministries. Some of these individuals go on to set up and work in training institutions, building sustainability and capacity into the system. They can become powerful advocates for the mobilisation and accountable use of resources, from both central and local government and also from the private sector, from local citizens and from the diaspora. The following example of a creative human resource network from Somaliland demonstrates the importance of investing long term in good-quality staff and in adopting a flexible and dynamic approach to building state capacity.

Somaliland exists as a *de facto* semi-autonomous state with little international *de jure* recognition, linked to two other Somali political zones – Puntland and South Central Somalia. One DFID-supported partner in Somaliland that has invested in human resource development in the health sector is the Tropical Health Education Trust (THET), working in partnership with King's College Hospital in London. THET has developed strong links with 14 Somali institutions and professional organisations.⁵ THET support has included the training of nursing tutors, nurses, midwives and doctors.

THET's model of support has the following key features:

- long-term involvement
- relationships with a network of dynamic Somali leaders and social entrepreneurs
- close collaboration with the MOH and other ministries, and support for MOH capacity-building where possible
- links to expertise in London via King's College Hospital and now King's Health Partners, one of the UK's new Academic Health Sciences Centres,⁶ which promotes high standards, quality training and research
- a creative network of state, international and local NGO, academic, private and public actors.

Edna Adan Ismail was a nurse brought across from the British Somaliland Protectorate to the UK to be trained as a nurse and to help strengthen the NHS workforce. Her future career included becoming Somalia's First Lady, Foreign Minister and Minister of Family Welfare and Social Development. THET started by supporting a private not-for-profit maternity hospital set up by Edna Adan Ismail that aimed to reduce the high infant and maternal mortality around Hargeisa. THET has gone on to develop links with other public and private hospitals and health institutions⁷ in Somaliland.

This example of THET's work illustrates an imaginative approach to supporting the health

sector, with a potential impact on wider state-building. Support is in the form of training a professional health class (providing jobs and a skilled workforce), encouraging Somali entrepreneurs, supporting Somali institutions that can increasingly become adopted by the state, promoting high standards of healthcare, impacting on mortality and morbidity, and working to lessen health inequities, particularly as the programme is 'mainstreamed' via an international donor that encourages this capacity-building policy and the use of human resources in the other two Somali political zones. THET plans to work with the MOH to create a national health plan in Somaliland and further develop the human resource strategy with potential hybridisation into other zones. THET also plans to support roll-out of the Essential Package of Health Services and to work in collaboration with public, private, academic and NGO service-providers. It serves as a model of what could be achieved in other sectors and provides a good example of networking between private and public service providers with government ministries.

This example highlights the importance of investing in training and the motivation of the health workforce, with a diversity of organisational arrangement and 'blurring of the boundaries' between public and private (IDS 2005).

3.2 Quality health service delivery

There is a *technical imperative* for health services to be provided to the highest standard. But the fragile state does not have the capacity to manage the resources required to act as service-provider for all its people. A flexible model of service delivery may be provided using a combination of national healthcare staff, international NGOs, community-based organisations and private contractors. The role of the state is then one of standardising, regulating and monitoring performance. The following examples from the DRC illustrate the role of different actors in service provision, the need for strong citizen engagement in service provision, and why the state must have an enhanced policy role to avoid service-providers bypassing the state and undermining legitimacy. The provision of good-quality services makes a significant contribution to mobilising citizen involvement in demand-side processes essential to the social contract, and to improving supply-side processes for greater accountability, which can demonstrate state effectiveness (even if services are provided by a diverse range of providers). Good-quality, improved, equitable health service delivery may also contribute to peace processes.

Good-quality health service delivery

Good-quality health service delivery by international and national organisations working in close collaboration with the Ministry of Health can play a significant role in increasing the confidence of citizens in government health services. It is important that the Ministry of Health regulates and standardises these interventions to ensure a good and equal coverage of service provision, and to improve the accountability of both the state and service-providers.

In the 1980s, the former Zaire was regarded to have had one of the better primary healthcare structures in sub-Saharan Africa. This gradually fell into disrepair with the loss of control of all functions of government (donors withdrawing support). Service provision had not so much been decentralised in Mobutu's Zaire as abandoned to local organisations that had to fill the gap. By 1998 half of the newly named DRC was in the hands of proxy rebel movements. Donors started re-engaging in the country from 2001, with initially 'humanitarian' programming in the east gradually being replaced with longer-term programming. The MOH provided a policy lead and was able to standardise healthcare provision via a Minimum Package of Health Services. Health authorities from areas of the country controlled by all of the armed groups came together to develop the package (Waldman 2006). Support to the then 515 health zones was via NGOs supported by donors that divided up ('balkanised') the country in different areas of support, while supporting the roll-out of MOH policy at the level of health facilities (Waldman 2006). Health has remained the strongest of the DRC's social sectors, with strong support from civil society and churches. Funding now comes primarily from international partners, with donors supporting specific health zones based on their previous support and capacity. Donor support was in line with the government's strategic framework programme. However, some zones are left without any support⁸ – for example, a health centre in a supported zone may have mosquito net distribution, rapid malaria tests and treatment, family planning and perinatal packages designed to reduce infant mortality, but a health centre in a neighbouring zone that is not supported will lack all of these programmes,⁹ contributing to geographical inequity in provision.

Even during the chaos of the war, when the country was divided and the DRC had the highest number of war-related deaths in the world at that time (Coghlan et al 2006), many NGOs, churches¹⁰ and private organisations were still providing health services via the local government structure of the health zone office (and in some cases regional health office). Community organisations played a

very important role in mobilising communities to meet their own healthcare needs during the years of the crumbling Mobutu regime and during the war years, and they continue to do so. Responsibility for thousands of healthcare facilities across the country were off-loaded by the Mobutu government onto church and private organisations, administered via health zones, effectively filling in for local government (with very few resources coming from the state). The Anglican church has a network of 53 health centres and hospitals that have continued with almost no support from the state during the war, and with only piecemeal support from donors and NGOs. This has meant that there is a very strong sense of community ownership of healthcare facilities, with community committees overseeing management of staff, drugs and finance. As the state is increasingly able (with or without donor support) to support more facilities they can rely on a strong existing level of community participation and cohesion that is already in place. A sense of entitlement is also created, with active citizens who have higher expectations of what government should deliver. This kind of bottom-up community empowering that promotes sustainability and ownership with tie-ins to local government should be given more recognition even if they are not as visible as programmes that improve governance at a central state level.

Medair was receiving both EC humanitarian (ECHO) and development (EuropeAid) funding for its programme in north-east DRC. While access became increasingly difficult from 2000 to 2005 in the region of Ituri, some supplies still reached health centres. National staff comprised many different religious and ethnic identities. While a fierce conflict between Hema and Lendu ethnic militia was destroying many lives and much healthcare infrastructure, Medair continued to employ staff from all ethnic groups, proving that a larger vision of identity was possible to achieve even during the worst of the conflict. In the slightly calmer, but still rebel-held, regions of Haut and Bas-Uélé, 250 health centres and 11 zonal hospitals were supported via the zone offices, with the zonal medical officers coming regularly for training and overseeing the

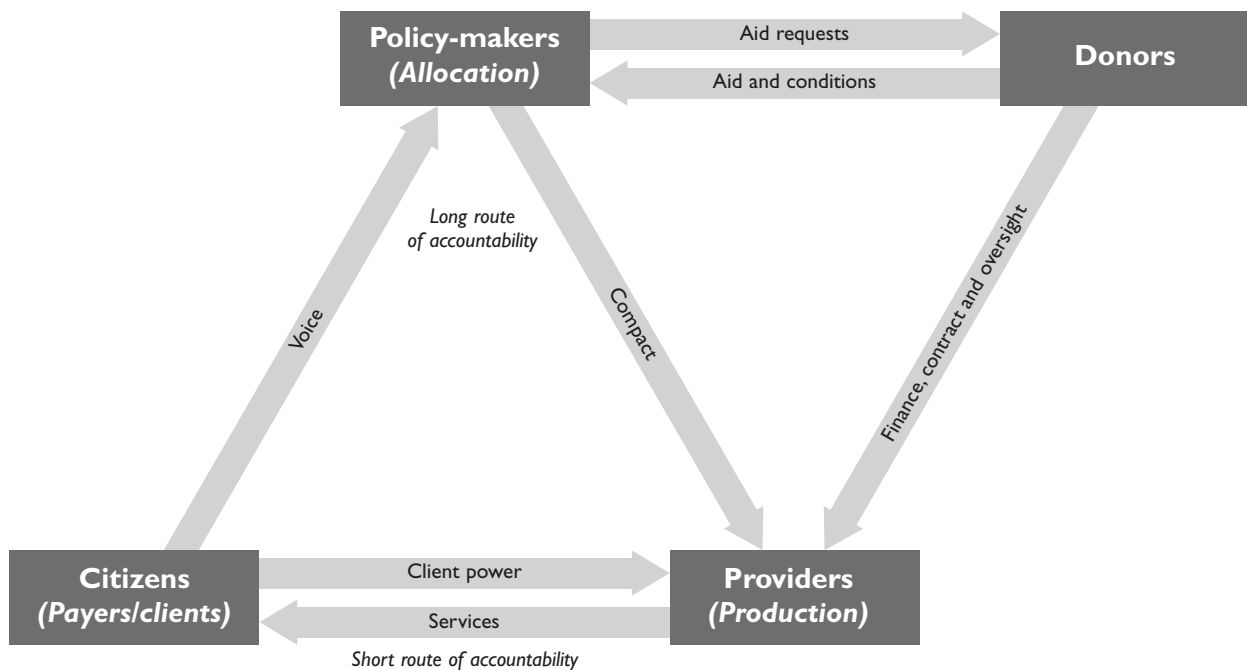
distribution of supplies. Using motorbikes, Medair staff reached around 80% of all the centres every month, accompanied by zonal administrators who were eventually enabled (with training, transport costs and salary support) to carry out the supervision visits themselves. When the DRC government regained control of the east, this zonal capacity was already in place. Improved service delivery in itself probably did not play a part in lessening violence at that time in eastern DRC (Waldman 2006). Peace returned to eastern DRC (in those areas that are currently more peaceful) through more serious international engagement in providing security and peace-building, with a sustained (and continuing) effort at demobilisation and security sector reform of DRC military and police forces, and through continued advocacy by networked NGOs.¹¹

This kind of quality healthcare programming plays a role in increasing the confidence of citizens in government health services and their perception as to the capacity of the government to provide social services. International support to central

state capacity in the DRC has been criticised as not sufficiently complemented with promotion of the civil society groups (OECD 2008) that provide a democratic check on the power of the state and that remind state ministries of their obligations towards citizens. Investments in networks of community-supported healthcare facilities is one way of increasing empowerment and in stimulating demand-side processes. But these investments must implicate local administration so that they contribute to state performance legitimacy, otherwise they risk weakening the links between state and society (Menocal 2009). The aim should be to promote positive state–society dynamics (Whaites 2008) and to reinforce the ‘long route of accountability’.

Whereas in a crisis situation donors may have to play a significant role in overseeing service providers (as in the contemporary Somali context), this capacity needs to be transferred to the MOH through consistent investments to restore capacity (including training, key technical assistance (TA) inputs, sustained financial support and improved accountability mechanisms). Partnership with the

The effect of donor support on the accountability triangle



Source: OECD 2008c

state then occurs via a gradual step-up process, with more resources allocated via the state as capacity increases. There also needs to be a significant investment in information and analysis (Pavignani and Colombo 2001) to ensure the fullest understanding of the health sector in order to streamline inputs and to ensure good-quality performance. In the Somali example, this role is played by the proposed Health Systems Analysis Team, whose functions could gradually be transferred to the MOH. At the same time, however, progress is not dependent only on the formation of formal institutions. The impact of some of the more flexible and unconventional arrangements for service delivery (with community-based organisations [CBOs] and NGOs, as in the above examples) may be harder to measure but can be significant in encouraging state–society engagement (IDS 2005).

The examples from the DRC demonstrate the potential for bypassing the state and working only on the ‘short route of accountability’. But in each case, the service-providers are officially recognised as providing district health services and efforts are made to improve supervision by district health staff. The health service is reinforced so that it can absorb more funding from the state should it be forthcoming. Most of the Congolese healthcare staff in all three examples will have a ‘numéro de matricule’ with the state, which *in theory* means they should be receiving a state salary. INGO or church programme staff give salary incentives to top up (or in the absence of) the state salary. The problems of healthcare programmes at that time (2003 to 2005) included the very unequal results in service provision from different contracted providers (Carlson et al 2005). This emphasises the need to reinforce the MOH role to regulate partners and standardise interventions.

As the central state becomes more capable of transparent financial management, donors should shift to budgetary support. Ohiorhenuan and Stewart (2008) stress the importance of routing assistance through the state and avoiding the

creation of parallel mechanisms for service delivery. An attractive model can be the contracting-out of services to a range of providers, paid directly from the state or from a pooled donor fund mechanism such as a multi-donor trust fund. Accountability is improved as the central MOH becomes stronger in formulating policy that outlines service delivery standards (such as the Minimum Package of Health Services in the DRC) and in monitoring and regulating providers via a *performance coordination unit* based in the MOH. Contracting in Cambodia contributed to poverty alleviation by reducing family health expenditure by 40% (Carlson et al 2005). In Afghanistan, it may have increased capacity in the MOH through skill transfer from those NGOs that had developed a broader public delivery role (Eldon et al 2008).

UNICEF in Uganda and UN agencies in Afghanistan have helped ministries of health to develop significant capacity in coordination, policy-making and regulation, while in Angola a lack of reinforcement of government–civil society engagement led to a disconnect in service provision and a lack of MOH policy lead (Carlson et al 2005). In Mozambique, where healthcare staff and facilities had been brutally targeted by insurgents, government legitimacy was enhanced before the ceasefire in 1992 through the MOH formulating health policy and creating a health information system across the country (with budgetary support from the Swiss Development Cooperation), and training staff from RENAMO areas (Vaux and Visman 2005, Pavignani and Colombo 2001). The successful and rapid recovery of the health sector in Mozambique played a catalytic role in the peace process because it was regarded as being politically significant. Realistic health policy set by the MOH was crucial in providing direction and keeping inputs consistent. When healthcare systems have been destroyed, there are new opportunities to build more equitable and sustainable healthcare provision if a long-term institutional approach is employed from the outset (Pavignani and Colombo 2001) that promotes government ownership and stewardship (Eldon et al 2008).

3.3 Promoting citizen voice, accountability and inclusiveness

This section examines the relationship of the health sector to democratic processes. Recent approaches to encouraging the strengthening of democracy have centred on investments in governance, which have largely not included the health sector. Well-designed health interventions can engage citizens in demand-side processes and in *public reasoning* about the *right to health*, which can increase the accountability of states, service-providers and donors. Such interventions can also help excluded and marginalised groups to be more democratically aware, contributing to increasing their *political agency* and to more equitable resource allocation. Enhanced citizen engagement and appropriate healthcare system design can contribute to reducing inequities, marginalisation and discrimination, and contribute to stability. Promoting more inclusive processes and improved services may also lessen the risk of conflict in marginalised areas and slums.

Democratic elections have been set as the culmination of good governance processes. But this approach has been increasingly scrutinised, partly because in some states elections have often had contested outcomes with outbreaks of violence, as in Kenya in December 2008. Countries in democratic transition are more prone to violence

(Stewart and Brown 2009). The most dangerous states are those with nominal democracies that have dominant executives and high levels of factional competition (Goldstone and Ulfelder 2004, Goldstone et al 2005). Democracy potentially attracts political candidates with criminal records, can increase levels of political violence and can worsen indicators of governance and accountability (Collier 2009). Elections are thus promoted as being intrinsically desirable but not as mechanisms for promoting peace (Collier et al 2006). Collier argues that the *political imperative* should follow on an improvement in the security situation and an improvement in economic and social wellbeing. The focus should be on creating jobs (particularly for young men, most easily provided in the construction sector¹²) to improve basic services (*particularly health*) and improving government financial management (*clean government*) (OECD 2009). But the intention to delay elections until other processes of accountability and state-building have already taken place (*gradualism*) is neither feasible or necessarily desirable, as without democracy the rule of law cannot develop. Others argue that state-building and the pursuit of democracy are processes that ideally happen at the same time. Outside actors have only a limited role in the democratic transition – they can back them but not drive or shape them (Carothers 2007).

Promoting citizen voice, accountability and inclusiveness

The health sector plays a role in promoting citizen voice and improving accountability and inclusiveness through engagement with citizens at the local level. This can be through local committees that oversee the way in which resources for health are used, holding service providers and local government accountable for the services provided.

The health sector has little involvement in formal democratic processes such as the creation of political parties or electoral commissions, or in influencing many of the underlying factors that influence successful democratic transition, such as the level of economic development and the sources of wealth,¹³ the level of political pluralism or the level of identity-based divisions in the country (Carothers 2007). But well-conceived health interventions that encourage citizen engagement in demand-side processes may increase citizen voice and participation in analysing the causes of ill health and poverty in communities, and potentially increase state accountability. In this scenario, democracy is not just about elections but about engaged *public reasoning* at community level. The health sector works through a range of state and non-state actors in service provision that interacts with citizens. It has more opportunities than other sectors to give a voice to marginalised groups such as women, children, the elderly and those with disabilities who should often be the focus of targeted health interventions. This may be especially important in Africa, where the awareness of 'political rights' in demanding accountability from leaders is not well developed. Democratic awareness needs to start locally as people engage in issues that directly affect them (such as access to healthcare) and learn to assert their rights as citizens (Bratton and Logan 2006). The right to health is one of many places to start, especially in fragile states that have such high rates of under-5 and maternal mortality. In well-designed health programmes, citizens can express their right to decreased mortality and morbidity and can demand that adequate resources are invested locally (and equitably) to meet these needs and are spent transparently. Ideally, citizens are involved in *inclusive*¹⁴ local committees overseeing how local, national *and donor* resources are used. Donors as well as states must become more accountable¹⁵ to the citizens they serve.

It is common practice for service providers to relate to citizens via representative health/development committees. These take many forms, from politically accountable village development committees to health facility management committees; they may be organised by community-

based organisations or women's groups. NGOs are not necessarily well placed to represent the interests of citizens, apart from local women's NGOs, which are best at linking with local constituencies (Ottaway and Carothers 2000). In Brazil, civil society actors were found to be more effective at representing the poor and marginalised if they were well connected to local political actors and state agencies (Lavalle et al 2005).¹⁶

Amartya Sen makes the point that democracy is as much about public discussion (*reasoning*) as about balloting, and that a more determined use of political and social voice via inclusive and interactive processes strengthens democracy. Here, the health sector does have a role to play in promoting the voice of the excluded and marginalised and in the *formation of values* (Sen 2009), which requires openness of communication between representative citizen groups and local authorities and service-providers. The opinion of citizens is empowered if information about the health status of the local community is shared with them by health professionals to allow their informed critical scrutiny. But enhancing social justice requires *activism on the part of politically engaged citizens* (Sen 2009) as well as models of local leadership that promote public reasoning. It may not be the role of service-providers to promote activism, but encouraging inclusiveness in the formation of community committees, sharing health information, being aware of second-generation rights such as the entitlement to medical care and promoting positive community dialogue mechanisms may help to stimulate better engagement, fairer representation and more *social monitoring*. 'The supply of good government is intricately linked to the demand for it' (Khan 2009). These community mechanisms may be stronger if combined with other sectors (water, sanitation, education and income generation) to address shared challenges.

Citizen engagement acts as an empowerment tool for local communities, contributing to grassroots representation, raising awareness of the rights and responsibilities of individuals and local representative structures, and creating improvements in the health status of the population.

This gives partial ownership to the prime stakeholders and increases accountability for the quality of healthcare in the facility, as well as empowering people to identify and act upon the prime causes of ill health, for example, dirty water, lack of sanitation, poverty and poor child feeding practices. Through citizen engagement, or community participation,¹⁷ people's *political agency* is enhanced. Increased engagement enables people to change their relationship with service-providers, be taken more seriously and begin to take greater responsibility for their own health. It also allows them to become more active as citizens in other arenas. Healthcare delivered via equitable priority service delivery with strong citizen engagement helps to lessen the sense of grievance and being neglected that can inflame ethnic tensions. Both enhanced citizen engagement and appropriate health system design can contribute to reducing inequities and marginalisation, and contribute to stability (Rubinstein 2009). The health sector is well placed to promote 'non-discrimination as a basis for inclusive and stable societies',¹⁸ gender equity, social inclusion and human rights. Exclusion of groups or regions of countries from political processes resulting in greater horizontal inequalities and discrimination have increased the probability of conflict in many countries, including Côte d'Ivoire, Indonesia, Guatemala and Sudan. It is likely that poor service access in regions of these countries contributed to decreased government legitimacy (Stewart and Brown 2009, Stewart 2008). The Maoist rebellion in Nepal was most intense in regions with higher rates of deprivation, particularly the mid and far west (Murshed and Gates 2005), suggesting that support for the Maoists was higher because of government failures to reduce poverty and provide services (Berry and Igboemeka 2005). The health sector plays a significant part in reducing inequalities alongside improved education, development and job creation. Also, the extent of exclusion and deprivation can be measured through health and poverty indicators.

In Nepal, the creation of participatory women's groups via village development committees in Makwanpur district had a significant impact on the lowering of both neonatal and maternal mortality

by changing homecare practices and whether or not women sought healthcare. The groups were facilitated by literate women from the village to discuss issues around childbirth (Manandhar and Costello 2004).¹⁹

Slums are examples of areas of extreme fragility in states with very high levels of horizontal inequality, and slum populations are excluded, voiceless and *capability deprived*. Rates of violence are much higher, particularly against women. Conditions will not change unless slum-dwellers are given more of a voice and become part of the solution (Khan 2009). This involves empowering them with information about health and poverty indicators and about levels of expenditure on health and social services (from state and non-state actors).

In Nairobi, 71% of the population live in slums, where a quarter of adults are unemployed. There is a high mortality burden from preventable diseases such as pneumonia, diarrhoea, HIV and tuberculosis. Children under five carry four times the mortality burden of the rest of the population living in the slums. The under-5 mortality rate in these areas in 2002 was estimated at 151 per 1,000 children, compared with the national average at that time of 115 per 1,000 (Kyobutungi et al 2008) and more than double the Nairobi average of 62 per 1,000. These are as bad as some of the more inaccessible rural drought-prone parts of the country. Slums in Nairobi are underserved by services such as health, water and sanitation, education and urban planning. All this needs more research by health specialists and social scientists, and health sector actors need to continue to help voiceless communities engage more with the state in demanding improved services and living conditions via more democratic and accountable government mechanisms. When citizens are brought more into accountability processes there can be significant results.

There is evidence from other sectors of the role of links between CBOs and state representatives in improving accountability of government institutions and service delivery. The proportion of people living in slums in Pune, India, increased from 12% to 40% between 1976 and 2003. The rapid growth of the

economy in the city was not accompanied by benefits in improved social facilities for residents of the slums who continued to suffer ill health and poverty from their poor and overcrowded environment. Illness pushed people further into poverty (Bapat 2009). In the slums of Pune and Mumbai, the empowerment of communities, especially women's groups, through alliances created between progressive municipal managers and CBOs, led to measurable improvements in slum sanitation, with community-designed, built and maintained toilet blocks. The voice of poor slum-dwellers was heard by senior state officials, who came to recognise that the realities of slum life are best appreciated by those who live in them (Burra et al 2003).

The urban and rural poor must be involved in participatory processes to transform their lives. This is a fundamental process in state-building, without which states are unlikely to become accountable, capable or able to address horizontal inequalities. Giving marginalised people a voice in fragile situations and increasing their representation in local government is critical to improving state performance. Research is needed to show the specific links that health sector interventions which maximise citizen voice and capability have on improving state accountability and performance.

3.4 Monitoring and advocacy

The health sector plays an underdeveloped role in monitoring levels of disease, death and violence in fragile situations. Networks of data from health facilities across countries and epidemiological survey tools can create datasets for monitoring trends and impact with which health sector performance and violence-reduction strategies can be monitored. The role of the health sector in monitoring mortality is still controversial, but there is potential for international health partners to establish better tools and mechanisms with which death rates (from violence, malnutrition or disease), injury rates and rates of sexual violence can be used as a barometer of conflict or to highlight areas of extreme vulnerability within states, such as in slums (Pearson N 2009b). Health partners can

play a greater role as *monitors* or evidence-based *witnesses* of how the state uses or misuses its core security function, and can *advocate* for violence reduction via an enhanced rule-of-law function. Public health can help communities analyse the extent and causes of violence and help propose potential solutions, advocating for more accountable government but also enhancing local capabilities²⁰ based on the values and priorities of the people concerned.

In extreme circumstances, this monitoring role may need to be combined with outspokenness to present evidence on how an entire political regime has institutionalised control of the state to deny citizens the most basic of rights, or even to inflict violence on them. Reasoning may need to be combined with indignation (Sen 2009),²¹ which is made stronger if followed by investigation into the causes of abuse or denial of rights. An example of this is Zimbabwe, which saw the collapse of its health service. Health professionals joined with other advocates to document and report on the effect this was having on the population in terms of spiralling death rates from common childhood preventable infectious diseases and malnutrition, HIV, tuberculosis, malaria, cholera and even plague (Tren et al 2007).

Monitoring mortality

Among the human development indicators used to determine levels of state fragility are maternal, under-5 and infant mortality rates. Not surprisingly, some of the highest rates of maternal mortality have been in the most fragile states (including Afghanistan, the DRC, Somalia, Liberia and Southern Sudan). Data analysis needs to be accompanied by joined-up efforts by states, donors and agencies to rapidly bring these rates down through improvements in maternal and child health, and also improvements in food availability, the provision of clean water, female literacy and poverty reduction strategies that require whole-of-government responses. Thus, the health sector can highlight extreme state fragility through health-sector indicators but must work across government departments and engage with citizens and all

Monitoring and advocacy

The health sector can play a key role in monitoring and witnessing levels of morbidity and mortality, sexual violence and physical violence within countries. This can be combined with advocacy for reduction in these levels, increased government accountability and local capacity, and speaking out when appropriate.

actors to both reduce mortality and advocate for reduced state fragility.

The Centre for Research on the Epidemiology of Disasters (CRED) holds the largest health database of conflict and natural disasters, but there is a huge data gap on mortality in fragile states, both in terms of numbers killed and causes of death. In most wars, there has been a failure to measure mortality effectively (Checchi 2010). Increasingly, epidemiologists are realising the importance of documenting all-cause mortality from conflict (Mills and Burkle 2009). Monitoring mortality will always attract controversy and be highly politicised. For example, the combined agency–Ugandan government surveys on areas of Uganda affected by the Lord's Resistance Army (LRA) conflict²² claiming that there had been over 1,000 deaths a week across three districts in the first half of 2005 (GOU et al 2005) were questioned by many and rejected by partners such as MSF.²³

The mortality reports from the International Rescue Committee (IRC) that estimated the increased death rates in eastern DRC between 1999 and 2008 have played a crucial role in mobilising funds and international commitment to resolving the war. They highlighted the extent of suffering in a country that had received very little international interest or engagement before 2003. There has been some recent criticism of the epidemiological techniques used in gathering

the data (Human Security Report (HSR) 2010),²⁴ claiming that they were overestimates based on incorrect mortality baselines. But one of the problems of the earlier studies was that IRC teams could not get into Ituri (where mortality rates were much higher than in other parts of eastern DRC because of the deadly nature of the inter-ethnic killing between 1999 and 2003 and because of lack of funding of agencies and poor access).²⁵ Epidemiologists will continue debating these data with the aim of refining techniques to increase accuracy for future surveys. But it is also possible that the IRC underestimated excess mortality in eastern DRC.

The various Iraq mortality datasets and surveys show huge differences in the estimated totals killed, and the number, causes and rates remain unclear (Tapp and Burkle 2008). The controversy generated by mortality data will not decrease but does point to the need for more investments in and standardisation of epidemiological tools to consolidate evidence, and more *prospective* community surveillance of mortality and nutrition (Checchi 2010), combined with systematic and repeated population estimates (Spiegel 2010) to establish more reliable baselines. If combined with surveys of ongoing levels of physical and sexual violence, it would provide a powerful advocacy tool for mobilising responses to reduce the causes of violence and make a substantial contribution to the monitoring of security and rule-of-law sectors in fragile states.

There is scope for more standardisation of reporting mechanisms within the health sector, improved epidemiological tools and an increased advocacy role. This would do more to highlight overlooked regions of extreme fragility within states, where rates of violence, disease and death are much higher, such as in urban slums or contexts like Karamoja in northern Uganda or Mindanao in the Philippines.

Monitoring sexual violence

Health personnel receive victims of physical and sexual violence in facilities and sometimes pass on information in confidence to specialist human rights organisations, but the health sector has not yet systematised the reporting of sexual violence. The DRC has one of the highest rates of sexual violence in the world, with 15,996 new cases documented in 2008, but there are huge discrepancies between datasets and the problem is likely to be substantially under-reported, and very few perpetrators are brought to justice. In North and South Kivu provinces 7,703 cases of sexual violence were recorded by the UN, but only 27 soldiers were convicted of crimes of sexual violence, and only three remain in prison (Human Rights Watch 2009). As long as impunity continues, the extensive crimes of rape carried out by national army, rebels and civilians plaguing eastern DRC will continue. A very high rate of sexual violence is also a feature of non-conflict violence in South Africa. The country was recently reported to have had deaths from injury, principally from interpersonal violence, at twice global levels (Seedat et al 2009).²⁶ In 2005 there were 55,000 cases of rape of women and girls reported to the police. Homicide of women by intimate partners was six times the global average.²⁷ This suggests systematic fragility in cultural and law enforcement domains in the country. The health sector needs stronger systems to measure and highlight the extent of sexual violence in both conflict and non-conflict settings to advocate for reinforcing of the rule of law sector.

Monitoring physical violence

Health professionals have been successful in preventing communicable diseases but rarely feel

involved in preventing violence in conflicts.²⁸ The WHO *World Report on Violence and Health* (Krug 2002) was, in part, a determination to overcome this blind spot in the health sector by applying a public-health approach to violence.²⁹ Violence, like other causes of morbidity and mortality, can be analysed through surveillance and monitoring.³⁰ The risk factors, causes and extent of the violence must first be understood through surveillance, health facility records, community data and cluster studies. Policy and programmed interventions are designed to address the problem. The interventions are then evaluated to measure impact (Mercy 1993). Increasingly, public health practitioners are investigating the causes of domestic violence and promoting effective prevention strategies,³¹ moving from merely reacting to violence towards working to lessen social, behavioural, environmental and economic factors that contribute to violence. Public health multidisciplinary prevention strategies provide comprehensive knowledge about violence, cement collaboration across sectors (including security, law enforcement and the judiciary, humanitarian and human rights, education, health and civil society), and empower citizen voice and mobilisation. The 'dirty war index' (Hicks and Spagat 2002) is a tool that potentially serves as a barometer of war, monitoring civilian deaths, injury and torture, but could be expanded to include sexual violence.

Morbidity and mortality from violence can be recorded confidentially by health facilities in a similar way to communicable disease, including descriptions of the cause of the violence. The extent of the problem is recorded, both in the health facility and among the population. Data on violent injury and death need to be better disaggregated by cause (Hazen 2008) and include more details on the type of weapon used and the category of person who committed the offence. A new injury surveillance system has been advocated by the newly created Geneva Declaration (Zavala and Hazen 2009). The Declaration, endorsed by 105 countries, is an important new initiative from the UN Programme of Action on Small Arms and Light Weapons³² to document injury from armed violence and support small-arms control. Coming

out of the Geneva Declaration, the Timor-Leste Armed Violence Assessment seeks concrete ways of reducing armed violence. It established a database to enable the tracking of armed violence and to guide policy options.³³ One data source is emergency rooms of health facilities, but to provide useable data this needs to be standardised, rich in detail and collected systematically (TLAVA 2009).³⁴ There is scope for health organisations to become affiliated with the Geneva Declaration and bring public health expertise into data collection and research on violence in conflict. Frameworks need to be developed for violence data surveillance, monitoring and evaluation. A violence surveillance system feeds into an early warning system that quickly detects any new epidemics of violence.

A region of sub-state fragility is Mindanao in the Philippines. Every year there are hundreds of victims of targeted killings in the Philippines that the National Police fail to seriously investigate (Human Rights Watch 2009a). In a continuing spate of political violence in Mindanao, 57 people were killed on 23 November 2009. The Philippines illustrate the way in which high crime rates, political violence and separatist wars merge into ongoing high rates of violence on the streets and in the provinces (Reed 2007). Improved reporting of gun wounds in casualty departments can be used to advocate for enforced and more accountable policing.

3.5 Global initiatives

There is increasing recognition among the populations of fragile states of the developing global norms of democracy, human rights and political inclusion (Whaites 2008). The international community also has increased expectations as to how states should perform (OECD 2008b). At the same time, national health ministry staff have raised expectations that donors should become more transparent by better aligning their support to national priorities instead of constantly creating new initiatives, new players and parallel priorities (GEGP 2008, Sridhar 2010).

The global health community has certain expectations of what constitutes minimal health service provision. The *right to health* is a developing concept coming from the human rights conventions and treaties of the past 60 years.³⁵ The Alma-Ata Declaration and General Comment 14 (on article 12 of the ICESCR) commits signatories to having comprehensive national health plans with clear objectives and timeframes for progressive implementation, and implementation of plans monitored with quality data. Participation, equity and non-discrimination should be features of these systems (Backman et al 2008). Most countries have not yet incorporated the right to health into domestic legislature, but the creation by the

Global initiatives

Global initiatives in the health sector have played a critical role in achieving global agreements on health policy, development of standardised guidelines and creating global standards. These can provide important benchmarks that governments can aim for. Some initiatives have been shown to provide useful financing channels, but it is important that these should also have a state-building agenda and be in line with government and national health plans.

Ugandan Human Rights Commission of a Right to Health Unit led to improved health policy and practice (Backman et al 2008).

The demographic and health surveys supported around the world by USAID have become benchmarks for standardised cross-population data collection of under-5 mortality, access to clean water and sanitation, and nutritional status. Minimum Service Packages are used now by many fragile states to standardise service provision around evidence-based health interventions. WHO treatment guidelines have become standards for effective treatment of many diseases. The WHO–UNICEF Integrated Management of Childhood Illness programme and the Expanded Programme of Immunisation provide blueprints for improving childhood nutrition, health and survival. The Millennium Development Goals act as beacons to which many states aspire in reducing poverty and under-5 mortality. There are, inevitably, areas of disastrous neglect in global health governance in fragile states, for example, in good-quality programming for chronic disease prevention and treatment, reproductive and perinatal health, mental illness and disabilities. By applying these standards, state ministries will help to fulfil the expectations of their citizens (reinforcing the social contract) while meeting certain growing international norms that give respectability to the state and help create a compact with the international community. Even authoritarian states seek to meet minimum health and development standards represented in such goals as the MDGs.

Global health initiatives (GHIs) such as the Global Fund and GAVI have brought in new funds for reducing mortality from particular diseases, with an intention, and some success, to link into wider health-system strengthening. GHIs create, however, distortions in health programmes and have not been sufficiently aligned to national health priorities and sector-wide approaches (Pearson M et al 2009). There have been calls for a single Global Health Fund to support all primary healthcare needs (Ooms 2009) as a way of reducing distortions in international health financing, and, potentially, to increase harmonisation and alignment, taking into

account the need to balance this with efforts to increase the tax revenues of fragile states to enhance the social contract and increase state accountability to citizens. UNITAID³⁶ is an imaginative example of how tapping into new forms of financing/taxation have been used to leverage price reductions for the treatment of malaria, tuberculosis and HIV. Initially pioneered by wealthier countries like France and Chile introducing an air tax, now countries like Niger, Madagascar and Côte d'Ivoire have applied the same tax. Instead of being just recipients of the funding they are also donors, thus contributing to processes of fiscal strengthening, improved financial management and greater resource accountability in a fragile state. It also encourages industry to invest in research and development and provides an example of how the health sector can positively influence market mechanisms.

Globally shared responsibility,³⁷ while playing an important role, must not simultaneously detract from the responsibilities of state governments. It is important that global financing mechanisms should also have a state-building agenda, be more flexible and contribute to harmonisation of national health plans and not exacerbate the healthcare human resource crisis (Sridhar and Tamashiro 2010).

3.6 Resource allocation

Public finance management accountability (Ghani and Lockhart 2009) and increasing tax revenue are key factors in heightening state resilience. What role does the health sector have in influencing public finances and accountability and local decisions of resource allocation? There is an emerging consensus that removing user fees from healthcare provision greatly increases access to health services for the poorest and most marginalised, whose spending on healthcare is a disproportionate burden on their limited resources and can push families further into poverty or destitution. Providing for this increased demand is costly and needs predictable and substantial financing. At the same time, there is growing consensus that health services are better run and more accountable if there is active participation by target stakeholders.

Resource allocation

The health sector can make a very significant contribution to state-building in fragile states by arguing for the need for increased taxation, contributing to the discussion on mechanisms for increasing fiscal revenue and creating more citizen mechanisms for monitoring the use of public funds.

These three potentially conflicting dilemmas (need for free primary healthcare services, need for predictable funding and citizen participation) are not necessarily mutually exclusive and can be brought together to strengthen the social contract, advocate for improved public fiscal management and have a knock-on effect on state legitimacy. By arguing for the need for increased taxation, by contributing to the discussion on mechanisms for increasing fiscal revenue and by creating more citizen mechanisms for monitoring use of public funds, the health sector can make a very significant contribution to state-building in fragile states.

User fees

The case against user fees has been well researched.³⁸ User fees have been shown to contribute to poor utilisation of services and exclusion of the poor and marginalised, they can contribute to pushing people into poverty, and they do not generate significant revenues. This realisation has prompted the governments of many poor and fragile states to pass policy measures to remove fees for reproductive healthcare and for children under five (Yates 2006).

The removal of user fees for primary healthcare in Africa

In 2000 almost every country in Africa charged fees for primary healthcare

Niger free for under 5s and deliveries, 2006

Senegal free deliveries, 2006

Liberia all services free, February 2007

Burundi free for under 5s and deliveries, August 2006

Zambia free services in rural districts, April 2006

South Africa free primary healthcare, 1994 and 1996

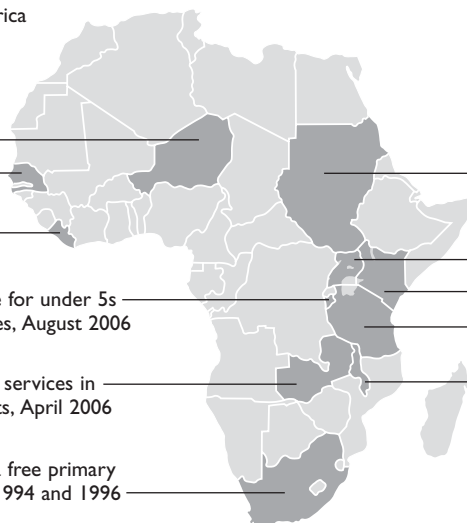
Sudan free services for under 5s and c-sections, February 2008

Uganda all services free, March 2001

Kenya free deliveries, October 2007

Tanzania free services for under 5s and maternity, 1993

Malawi has never charged fees



Source: Robert Yates, Department for International Development

Niger experienced a food crisis in 2005 with very high rates of acute malnutrition. The crisis was caused more by a collapse in purchasing power than a shortage of food.³⁹ A major humanitarian response helped to reduce the acute malnutrition crisis and may have contributed to the marked decrease in infant mortality, as measured in the Demographic and Health Survey 2006, from 81 per 1,000 compared to 123 per 1,000 in 1998. The response also highlighted the links between the cost of healthcare, poverty and malnutrition. A positive outcome of the crisis was that it led to national and international agencies campaigning for the removal of user fees. In 2005 the government passed legislation to remove the fee for caesarean sections and then for under-5 care and family planning in 2006.⁴⁰ This is an illustration of how the health sector has to work closely with Ministry of Finance and the legislative branch in determining health policy and spending priorities, and also how a health crisis of acute malnutrition and child death is linked very closely with government policies controlling markets and healthcare. It also demonstrates the relationship between global health consensus and the prioritising of policies in national health systems. More time will be needed to evaluate the effect of removing user fees on health status and poverty reduction in Niger, and to see the wider effects of the intensive input of international interest and response on longer-term state capacity and effectiveness.

The need for predictable funding

Scrapping user fees in Uganda was helped by having a strong executive lead. It resulted in the health sector negotiating a 40% increase in the health budget allocated by the Ministry of Finance in order to meet growing public expectations. It also enabled the MOH to increase salaries for health staff (Yates 2006) and led to a growing public sector budget. As Ugandan government financing of the health sector increased, direct donor support decreased (although substantial contributions are given as budgetary support) (McPake et al 2008). So in the Ugandan example, advocating for the scrapping of user fees increased the total budgetary

allocation to the health sector and may have contributed to state legitimacy and effectiveness (in, for example, revenue collection).⁴¹ States that are more dependent on domestic taxpayers for their budget must improve the quality of their governance to maintain legitimacy via a consensual sharing of authority (Moore 2004). State authorities in Kaduna state, Nigeria, prioritised health service governance and provision, increased the budget for health and became more accountable to citizens. In Sierra Leone, a real increase in public and health expenditure was associated with improvements in governance and state-building (Eldon et al 2008). Because donors and NGOs have been better at spending than encouraging the raising of revenues, the *fiscal imperative* in state-building has been downplayed. The health sector needs to engage with other sectors⁴² in promoting the importance of taxation in improving governance. Taxation is critical to developing the social contract and building relationships of accountability that link revenue-raising and spending with expectations and obligations (IDS 2005). There is a positive correlation between democracy, state accountability and increasing tax revenues, particularly when the revenues come from the poor (Brikci 2010).

Do these post-conflict examples have any relevance to a fragile state still in conflict? In the Somali Essential Package of Health Services (EPHS), it was proposed that the primary care package be free in health facilities. Currently, there is no standardised fee system across the three political zones of the country, with humanitarian organisations offering free health services and the many privately run Somali health facilities charging at varying rates. There is as yet no donor commitment to supporting country-wide health systems, but the EPHS is increasingly being piloted in certain regions, and UNICEF provides free drugs and equipment from most lower-level health facilities. While recognising that donors would initially have the major role in financing free primary healthcare for EPHS roll-out, the financial contribution of other sources has been identified, with the intention that the percentage of other contributions can gradually increase (Pearson and Muschell 2008).

Somalia Essential Package of Health Services: Financing contributions from five primary sources

Financing mechanism	Level of health facility					
	Phase I			Phase II		
	Primary health unit	Health centre	Hospital	Primary health unit	Health centre	Hospital
Community Health Fund	5%	5%	10%	15%	15%	15%
User fees	0	0	20%	0	0	20%
Ministries of Health regular budgets	5%	5%	10%	15%	15%	20%
Municipal/district contributions	5%	5%	10%	5%	5%	10%
Donor financing of agencies contracted to provide healthcare services	85%	85%	50%	65%	65%	35%

The community health fund model comes from health centres run by the Somali Red Crescent Society in which, rather than paying fees, citizens contribute financially to a fund when they have resources⁴³ or in kind (for example, helping with the construction of a health facility). Municipalities in port towns have contributed to healthcare, with a small percentage of revenue from port authorities given to hospitals (in the case of Berbera and Bosaso hospitals). There is, as yet, no government budget in South Central Somalia, but in Somaliland the MOH does pay small salaries for regional medical officers and some hospital staff. While current state capacity in the country is still very low, a model that taps into diverse potential sources of revenue will help to build sustainability into the health system and may lead to initiatives being taken by citizens and by local, regional and central state authorities that could eventually translate into increased state effectiveness, if combined with improved security, leadership, local accountability and increased fiscal management capacity. In a context where the central state is still very weak, service providers may be able to leverage regional councils to provide some resources for healthcare, especially in regions with greater levels of economic activity such as towns at borders or with ports.

Citizen monitoring of resource use

Although the temptation might be to dismiss the Somali health system as an exercise in wishful thinking, if this kind of structure is brought into health systems from the outset there is the potential to institutionalise the influence of society over taxation and expenditure (Moore 2004). As a state becomes more dependent on the poor for its tax revenues the more accountable it must become to them.⁴⁴ Service providers need to promote the 'watchdog' role of civil society in monitoring how governments and external agencies are performing to ensure a higher impact on fragile health systems (McCoy et al 2009).

Particular contexts

3.7 Stabilisation

Where does the health sector fit in with *stabilisation*, and how does stabilisation fit in with state-building? The aim of stabilisation is seen primarily as regaining national and human security,⁴⁵ followed by the

long-term state-building processes of economic and infrastructure development, governance and rule of law. *Securitisation* is one of the survival functions of a state that may at times in some conflicts be provided by external actors. In an acute security crisis, or in a chronic political crisis, the need to ensure the provision of health services is not well served if included within a military stabilisation agenda. Mixing counter-insurgency operations with the restoration of services clearly creates the risk of these services being targeted by insurgents (Baker 2010) and so the coordination of service provision is better served wherever possible by purely civilian (and ideally host government) teams.

The need for security is regarded by defence analysts as being ‘non-discretionary’ (MOD 2009), in other words, it is a minimum requirement for other sectors to function. Furthermore, defence analysts agree that the *security imperative* has to be combined with a comprehensive approach to economic development and governance (MOD 2009) (ie, with a state-building agenda). It may not, however, be possible to achieve security in the absence of improvements to political governance (OECD 2008). There is also little causal link between military coordinated reconstruction and improved securitisation.⁴⁶

‘Hearts and minds’ interventions designed to promote the goodwill of an armed actor may in fact undermine efforts to bolster host-state legitimacy and promote citizen participation and capacity. Military medical civilian assistance programmes, for instance, may have oriented people away from local medical services (Rubenstein 2009, Wilder 2009). Whether the military can undertake ‘medical stabilisation operations’ is debatable, even if they are carefully coordinated with national and international partners with the aim of improving government legitimacy (Baker 2010). The role of the military medics during a stabilisation phase will primarily be to provide life-saving assistance in *non-permissive*⁴⁷ environments until government and civilian actors are able to undertake humanitarian interventions, linked in with system-strengthening as soon as possible. Quick impact projects within a stabilisation framework are designed to rapidly

restore emergency public services, but are unlikely to affect health-system strengthening and are best used in an acute phase when alternative approaches are not viable.

Donor assistance when delivered for services in Afghanistan as part of a military ‘hearts and minds’ strategy may also undermine stability (Wilder 2009, Feinstein 2009). In Iraq, there are suggestions that investments put into health reconstruction projects via a securitisation agenda did not make sufficient inroads into improving healthcare, with the bulk of investment being channelled via US construction companies, which US government auditors strongly criticised for failing to honour contracts. Only after overseeing this poorly accountable expenditure was the importance of investing in governance, policy reform and increasing capacity of Iraqi institutions acknowledged (Webster 2009). Spending in the health sector was severely distorted, with large sums put into construction and little attention given to health systems and reinforcing primary care (Pearson N 2009). A basic service package was not developed until 2008. Even at the time of the initial occupation of Iraq, analysis suggests that armed forces should not have played a lead role in humanitarian assistance (Burkle and Noji 2004). The prime aim of stabilisation operations should rather be restoring security that will permit civilian, national and other actors to restore services. The health agenda might therefore be better considered as *independent* of a securitisation-stabilisation agenda.

The more secure a situation, the easier it is to carry out effective emergency health and rescue response, but even in the most *non-permissive* of environments, there will be national health actors responding in some way, often at great personal risk. Patient negotiation with belligerent groups has led to access in even the worst scenarios, such as in parts of eastern DRC at the height of militia activity in Ituri in 2003 (Pottier 2006), but health programming at this time was in survival mode and supplies got through in a very erratic fashion, with large concentrations of citizens not being accessed by aid organisations. NGOs lobbied the international community for security conditions

that would enable health operations to continue. In the town of Bunia this was eventually provided by the deployment of a French-led multinational force (Operation Artemis) that handed over to an enhanced UN peacekeeping force (Bernath and Pearson 2003), which gradually created more secure space in Ituri. NGOs coordinated closely with the military and at times where there were no alternatives used military escorts, but the military were rarely directly involved in implementing health activities in the health facilities across Ituri.

There is a need for more precise use of terms such as *stabilisation* (as securitisation, the process of consolidating security) and peace-building (the process of establishing and institutionalising peace) so that the core state-building processes are not subsumed in them, creating confusion in the roles of different sectors and actors. The provision of equitable health services may well help reduce grievance, marginalisation and tension, and thereby improve security, yet there is no hard evidence to prove that this is the case. Even if it were, this does not mean that the health sector should be part of a securitisation agenda. It is in any case questionable whether health service provision enhances state legitimacy in the short term (Rubenstein 2009).

3.8 Decentralisation

There are suggestions (from Nigeria and Sierra Leone – Eldon et al 2008) that the state–society contract develops more readily at sub-national level, especially when there is strong national support for decentralisation policies. As previously

demonstrated, at this level there is scope for more citizen engagement and opportunity for greater accountability of local politicians, but also for elite capture and political repression. Local governments need to be empowered to raise sufficient resources (Commins 2009).⁴⁸ Political factors can block the expected service delivery benefits of decentralisation (as well as administrative and fiscal constraints) and long-term conflict can, in fact, be exacerbated (Scott 2009).⁴⁹ The implication is that a decentralised government will not be able to provide what a central government has failed to deliver. For service delivery to be effectively provided by local government (with potential beneficial effects on economic recovery) there needs to be strong central political commitment (and presumably capacity) and robust accountability mechanisms to avoid elite capture (Scott 2009). For health agencies, the implication is that if they want to enhance the social contract then the political and economic context must be analysed to ensure effective service delivery via local state actors. If services are over-decentralised, with multiple sources of finance, citizens' trust in their government may be damaged and they may perceive that service delivery is deteriorating (as in Indonesia after decentralisation in 2001 [Commins 2009]).⁵⁰ But for many fragile states (for example, the DRC, Chad, Somalia) the increased provision of local services is not a decentralisation process because the central state never provided the services in the first place.

4 Conclusion

State-building is highly country specific and primarily an internal process between citizens and the political elite. Interventions in the health sector, be they with a 'developmental' or 'humanitarian' lens, will always affect the interaction between citizen, service-provider and policy-maker, whether intended or not, and international partners should aim to ensure that sector-specific interventions will affect these processes in ways that reinforce, rather than undermine, state resilience. Even during conflict or after disasters, or in states with little *de facto* jurisdiction over large areas of territory, aspects of state-building can still be supported. Well-designed health interventions can rebuild capacity at sub-national level even when there is weak central government, and can support democratic processes of public reasoning and consent-building in terms of citizen expectations of rights and responsibilities, which are as vital as more visible forms of democracy such as creating political parties and holding elections. Engaging citizens in identifying causes of ill health (including looking at causes of violence) and in healthcare delivery can be a powerful tool for creating demand for a stronger social contract and, by degrees, a more just and effective state. Governments will never become capable and accountable unless citizens are actively engaged in demanding accountability of state resource investments and in ensuring performance. International health partners help to highlight healthcare standards and the right to health to

which states are encouraged to aspire; this further strengthens state accountability. The health sector needs to identify how more coherent programming and better governance can bring improved health status and can create more robust systems to reduce inequalities, destitution and fragility. Long-term investments in training and the deployment of health workers build sustainability in the health sector and potentially generate leaders at regional and national level.

State-building cannot wait until there is no conflict, no crisis, no large-scale human rights neglect or no semi-authoritarian regime. Fragile states without apparent conflict or current natural disaster may still have unacceptably high levels of violence, sexual violence and maternal and infant mortality. State-building activities can and should start during the crisis by degrees and using flexible, context-specific interventions. The health sector has a prominent role to play in engaging with wider state-building processes that will contribute to greater state resilience. These roles include promoting citizen voice and participation, monitoring abuses and unacceptable rates of mortality and morbidity, encouraging diversified resource mobilisation for sustainable service provision, investments in human capital, good-quality service provision and inclusive access, and promoting international technical standards of good-quality healthcare.

References

- Backman G et al (2008) *Health systems and the right to health: an assessment of 194 countries*. Lancet 372:2047–85
- Bailey S et al (2009) *Early recovery: an overview of policy debates and operational challenges*. HPG Working paper. ODI
- Baker J (2010) *The doctrinal basis for medical stability operations*. Military Medicine 175:1; 14–20
- Bapat M (2009) *Poverty lines and lives of the poor. Underestimation of urban poverty – the case of India*. IIED working paper No 20
- Beranger J and Horsey R (2008) *Negotiating humanitarian access to cyclone-affected areas of Myanmar: a review*. Humanitarian Exchange ODI Number 41
- Bernath C and Pearson N (2003) *MONUC: mandate to succeed*. 2003 Refugees International. http://repository.forcedmigration.org/show_metadata.jsp?pid=fmo:3159
- Berry C and Igboemeka A (2005) *Service provision in difficult environments: issues arising from DFID support to health sector interventions in Burma, Afghanistan and Nepal*. DFID
- Bratton M and Logan C (2006) *Voters but not yet citizens: the weak demand for vertical accountability in Africa's unclaimed democracies*. World Bank/Bank-Netherlands Partnership Programme
- Brikci N et al (2010) *Health financing – achieving universal coverage in low-income countries*. Save the Children UK (forthcoming)
- Brookings Institute (2008) Rice S and Stewart P. *Index of state weakness*
- Burkle F and Noji E (2004) *Health and politics in the 2003 war with Iraq: lessons learnt*. Lancet 364: 1371–5
- Burra S, Patel S and Kerr T (2003) *Community designed, built and managed toilet blocks in Indian cities*. Environment and Urbanization 15; 11:11–32
- Canavan A et al (2009) *Health-sector policy and funding gaps in post-conflict settings: a question of aid effectiveness in transitions*. HFSN and Royal Tropical Institute of the Netherlands
- Capobianco E and Naidu V (2008) *A review of health sector aid financing to Somalia (2000–2006)*. VVB Working Paper No. 142
- Carlson C et al (2005) *Improving the delivery of health and education services in difficult environments: lessons from case studies*. DFID Health Systems Resource Centre
- Carothers T (2007) *The “sequencing” fallacy. How democracies emerge*. Journ of Democr. 18; 1:12–27
- Checchi F (2010) *Estimating the number of civilian deaths from armed conflict*. Lancet 375:255–7
- Coghlan B et al (2006) *Mortality in the Democratic Republic of Congo: a nationwide survey*. The Lancet: 367; 44–51
- Collier P and Hoeffler A (2004) *Greed and grievance in civil war*. Oxford Economic Papers 56:563–595
- Collier P, Hoeffler A and Söderbom M (2006) *Post conflict risks*. Centre for the study of African Economies, University of Oxford
- Collier P (2007) *The bottom billion. Why the poorest countries are failing and what can be done about it*. OUP
- Collier P (2009) *Wars, guns and votes. Democracy in dangerous places*. The Bodley Head
- Collier P (2009 you tube) *New rules for rebuilding broken nations*. Talk to US State Dept June 2009 available on Ted talks: <http://www.youtube.com/watch?v=TvW4yugCPZo>
- Commins S (2009) *Basic services delivery in conflict affected and fragile states*. Conference paper for UNESCAP regional technical seminar
- Del Castillo G (2008) *Rebuilding war-torn states. The challenge of post-conflict reconstruction*. OUP
- De Walle S and Scott Z (2009) *The role of public services in state- and nation-building: exploring lessons from European history for fragile states*. GSDRC
- DFID (2009) Alexander J. *Building the state and securing the peace*
- DFID (2007) *Governance, Development and democratic politics*
- DFID (2010) *Working effectively in conflict-affected and fragile situations*. Briefing papers A – I. A: analysing conflict and fragility, D: Non-discrimination, E: Aligning with local priorities, F: Practical coordination mechanisms, I: Monitoring and evaluation
- DFID (2010a) *Building peaceful states and societies*. Forthcoming
- DFID Somalia (2010) *Programme memorandum. Harmonised support for the Somali health sector*. Forthcoming
- Eldon J, Waddington C and Hadi Y (2008) *Health system reconstruction: can it contribute to state-building?* HLSP and HFSN
- Feinstein (2009) *Understanding the relationship between aid and security*. Washington [https://wikis.uit.tufts.edu/confluence/display/FIC/Understanding+the+Relationship+Between+Aid+and+Security+\(Summary\)](https://wikis.uit.tufts.edu/confluence/display/FIC/Understanding+the+Relationship+Between+Aid+and+Security+(Summary))
- Foreign Policy and The Fund for Peace (2009) *Fragile states index*

- GEGP (2008) Global Economic Governance Programme. *Setting a developing country agenda for global health*. Preliminary report of a high-level working group. University of Oxford
- Ghani A and Lockhart C (2009) *Fixing failed states, a framework for rebuilding a fractured world*. OUP 2008, 2009
- Goldstone J and Ulfelder J (2004) *How to construct stable democracies*. *Washing Quart* 28; 1:9–20
- Goldstone et al (2005) *A global forecasting model of political instability*. *Americ Journ of Polit Science* 50; 1:190–208
- GOU MOH, WHO, UNICEF, WFP, UNFPA, IRC (2005) *Health and mortality survey among internally displaced persons in Gulu, Kitgum and Pader districts in northern Uganda*
- Hazen J (2008) *Armed violence in Asia and the Pacific: an overview of the causes, costs and consequences*. UNDP
- Healy S (2008) *Lost opportunities in the Horn of Africa. How conflicts connect and peace agreements unravel*. Chatham House
- Hicks M and Spagat M (2002) *The dirty war index: a public health and human rights tool for examining and monitoring armed conflict outcomes*. *PLoS Med* 5(12): e243
- Human Rights Watch (2009) *Soldiers who rape, commanders who condone. Sexual violence and military reform in the Democratic Republic of Congo*
- Human Rights Watch (2009a) *You can die at any time. Death squad killings in Mindanao*
- Human Security Report (HSR) (2009) *The shrinking costs of war*. Simon Fraser University
- IDS (2005) *Signposts to more effective states. Responding to governance challenges in developing countries*. IDS The Centre for the Future State
- Khan I (2009) *The unheard truth. Poverty and human rights*. Amnesty International. Norton
- Krasner S (2005) *Addressing state failure*
- Krug EG et al (2002) *World report on violence and health*. Geneva, WHO
- Kruk M et al (2010) *Rebuilding health systems to improve health and promote state-building in post-conflict countries: a theoretical framework and research-agenda*. *Social Sciences & Medicine* 70; 89–97
- Kostovicova D and Bojicic-Dzelilovic (eds) (2009) *Persistent state weakness in the global age*. Ashgate
- Kyobutungi C et al (2008) *The burden of disease profile of residents of Nairobi's slums: results from a demographic surveillance system*. *Population Health Metrics* 6:1
- Lavalle A, Acharya A and Houtzage P (2005) *Beyond comparative anecdotalism: Lessons on civil society and participation from São Paulo, Brazil*. *World Development* 33; 6:951–964
- Loevinsohn B and Harding A (2005) *Buying results: contracting for health service delivery in developing countries*. *Lancet* 366; 676–81
- Manandhar D, Costello A et al (2004) *Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial*. *Lancet* 364:970–79
- Marshall M and Cole B (2009) *Global Report 2009. Conflict, governance and state fragility*. Centre for Global Policy, George Mason University
- McCoy, Chand S and Sridhar D (2009) *Global health funding: how much, where it comes from and where it goes*. *Global Health Policy* 24:407–417
- McPake B et al (2008) *Freeing up health care: a guide to removing user fees*. Save the Children UK
- Menkhuas K (2009) *Somalia after the Ethiopian occupation. First steps to end the conflict and combat extremism*. Enough! Project
- Menocal A (2009) *'State-building for peace': navigating an arena of contradictions. Donors need to understand the links between peace-building and state-building*. ODI
- Mercy JA et al (1993) *Public health policy for preventing violence*. *Health Affairs* 12; 4:7–29
- Mills E and Burkle F (2009) *Interference, intimidation and measuring mortality in war*. *Lancet* 373; 1320–22
- MOD (2009) *Security and stabilisation: the military contribution*. Joint Doctrine Publication 3–40
- Murshed M and Gates S (2005) *Spatial-horizontal inequalities and Maoist insurgency in Nepal*. *Rev of Dev Econom* 9; 1:121–134
- Moore M et al (2005) *Signposts to more effective states*. IDS
- Moore M (2004) *Revenues, state formation and the quality of governance in developing countries*. *Int Pol Sc Rev* 25; 3:297–319
- Newbrander W (2007) *Rebuilding health systems and providing health in fragile states*. USAID, MSH Occasional paper No 7
- NRC (2009) *Research to improve the activities of INGO activities and future humanitarian coordination in Iraq*
- OECD (2005) *Principles for good international engagement in fragile states and situations*. OECD-DAC
- OECD (2007) *10 Principles for good engagement in fragile states*. OECD-DAC
- OECD (2008) *Concepts and dilemmas of state building in fragile situations. From fragility to resilience*
- OECD (2008a) *Resource flows to fragile and conflict-affected states*. Annual report 2008
- OECD (2008b) *State building in situations of fragility. Initial findings*
- OECD (2008c) *Service delivery in fragile situations. Key concepts, findings and lessons*
- OECD (2009) *Contracting out government functions and services*. Ch 5 Collier P. *Rethinking the provision of public services in post-conflict states*
- OECD (2009a) *Ensuring fragile states are not left behind*. Summary report March 2009
- Ohiorhenuan J and Stewart F (2008) *Post-conflict economic reconstruction*. UNDP
- Ooms G (2009) *From the global AIDS response towards global health? A discussion paper*. Hélène de Beir Foundation and International Civil Society Support Group
- Ottaway M (2002) *Rebuilding state institutions in collapsed states*. *Development & Change* 33; 5:1001–1023
- Ottaway M and Carothers T (2000) *Funding virtue: civil society, aid and democracy promotion*. Carnegie Endowment for International Peace

- Pavignani E, Corregia R and Pearson N (2008) *Steps towards harmonizing external support and health care provision for the Somali people*. DFID, EC and Italian Development Cooperation
- Pavignani E and Colombo S (2001) *Providing health services in countries disrupted by civil wars: a comparative analysis of Mozambique and Angola 1975–2000*. WHO
- Pearson N and Muschell J (2008) *Essential Package of Health Services* <http://www.somalisupportsecretariat.info/reports/publications/HealthSystem/Docs/Essential%20Package%20of%20Health%20Services-2.pdf>
- Pearson N (2009) *Middle East Scoping Mission*. Merlin internal document
- Pearson N (2009b) *Designing health systems for violence reduction in conflicts*. Unpublished
- Pearson M et al (2009) *Global health partnerships and country health systems: the case of Cambodia*. HLSP
- Political Instability Task Force and Centre for Global Policy at George Mason University. *Global report 2008, 2009* (State Fragility Index)
- Pottier J (2006) *Roadblock ethnography: negotiating humanitarian access in Ituri, Eastern DR Congo, 1999–2004*. *Journ of Intern Afric Inst* 76: 2; 151–179
- Reed L (2007) *Guns in the frame*. A photo essay. Small Arms Survey
- Rosser A (2006) *Achieving turn around in fragile states*. IDS bulletin 37.2
- Rubenstein L (2009) *Post-conflict health reconstruction: New foundations for US policy*. USIP
- Scott Z (2009) *Decentralisation, local development and social cohesion: an analytical review*. GSDRC
- Seedat M, Niekerk A, Jewkes R, Suffla S and Ratele K (2009) *Violence and injuries in South Africa: prioritising an agenda for intervention*. *Health in South Africa* 5 *Lancet* 374: 1011–22
- Sen A (2006) *Identity and violence – the illusion of identity*. Norton
- Sen A (2009) *The idea of justice*. Allen Lane. Chapters 15 (*Democracy as public reason*), 16 (*The practice of democracy*), 17 (*Human rights and global imperatives*), 18 (*Justice and the world*)
- Spiegel P et al (2010) *Health-care needs of people affected by conflict: future trends and changing frameworks*. *Lancet* 375: 341–5
- Sridhar D (2010) *Seven challenges in international development assistance for health*. *Journal of Law, Medicine and Ethics* (forthcoming)
- Sridhar D and Tamashiro T (2010) *Vertical funds in the health sector. Lessons for education from the global fund and GAVI*. UNESCO, GMR
- Stabilisation Unit (2008) *The UK approach to stabilisation*. Stabilisation Unit guidance notes (SU, the UK's tripartite stabilisation unit – DFID, MOD, FCO) http://www.stabilisationunit.gov.uk/resources/Stabilisation_guide.pdf
- Steinberg D (2009) *Development, security and transitions: challenges and opportunities for international engagement in fragile states*. International Crisis Group <http://www.crisisgroup.org/home/index.cfm?id=6316>
- Stewart F and Brown G et al (2009) *Fragile States*. CRISE working paper 51
- Stewart F (ed) (2008) *Horizontal inequalities and conflict. Understanding group violence in multiethnic societies*. Palgrave Macmillan
- Tapp C, Burkle F et al (2008) *Iraq war mortality estimates: a systematic review*. *Conf Health* 7; 2:1
- Ter Veen A et al (2009) *Health systems strengthening in fragile contexts: a report on good practices and new approaches*. Health and Fragile States Network. LSHTM
- TLAVA (2009) *Tracking violence in Timor-Leste, a sample of emergency room data 2006–08*. TLAVA Issue brief no 4
- Tren et al (2007) *Tyranny and disease. The destruction of health care in Zimbabwe*. Africa Fighting Malaria Occasional Paper
- Vaux T and Visman E (2005) *Service delivery in countries emerging from conflict*. Centre for International Cooperation And Security, University of Bradford for DFID
- Waldman R (2006) *DRC case study and (2007) Health programming for rebuilding states*
- Waldman R (2006) *Health in fragile states, country case study, DRC*. USAID Basics
- Webster P (2009) *Reconstruction efforts in Iraq failing health care*. *Lancet* 373: 617–20
- Whaites A (2008) *States in development: understanding state-building*. DFID
- WHO (2007) *Everybody's business: Strengthening health systems to improve health outcomes*. WHO's Framework for Action. WHO
- WHO Maximising Positive Synergies Collaborative Group (2009) *An assessment of interactions between global health initiatives and country health systems*. *Lancet* 373; 2137–69
- Wilder A (2009) *Middle East Institute Viewpoints: Afghanistan 1979–2009. In the grip of conflict*. p 143–146. MEI Washington https://wikis.uit.tufts.edu/confluence/download/attachments/32412871/wilder_MEI.pdf?version=1
- World Bank (2008) Menocal A, Othieno T and Evans A. *The World Bank in fragile situations: an issues paper*
- World Bank (2009) *Harmonised list of fragile situations*. http://siteresources.worldbank.org/EXTLICUS/Resources/511777-1247506883703/Fragile_Situations_List_FY10_Nov_17_2009_EXT.pdf
- Yates R (2006) *International experiences in removing user fees for health services – implications for Mozambique*. DFID Health Resource Centre
- Zavala D and Hazen J (2009) *Understanding violence. The role of injury surveillance systems in Africa*. Geneva Declaration Secretariat, Geneva

Endnotes

I Introduction

¹ In Haiti, not only are building regulations not enforced, but there are no building inspectors.

2 Concepts and definitions

² But 'complex emergency' is also applied to regions facing a common challenge, such as recurrent drought and conflict in the Horn of Africa.

³ What Sen (2006) refers to as a 'devised system of uniquely powerful categorisation'.

3 Health sector impact on wider state-building

⁴ There are many other domains not discussed, including the impact of institutional strengthening in the health sector on the wider public administration or of reconstructing infrastructure in the health sector on the market, or the influence of the health sector on key infrastructures, such as water and sanitation, or on urban planning, road construction and safety.

⁵ These include the Somaliland Nursing and Midwifery Association led by the impressive Fouzia Ismail, who has created six regional offices.

⁶ King's Health Partners is a pioneering collaboration between one of the world's leading research-led universities and three of London's most successful NHS Foundation Trusts.

⁷ These include a health professionals council and the Somaliland Medical Association.

⁸ A recent HFSN study estimated that 83 out of 515 health zones at that time had no external support (Canavan et al 2009).

⁹ This was witnessed by the author in zones in North Kivu in November 2009 in areas that were affected by the severe insecurity and open conflict that still exist in North and South Kivu.

¹⁰ It is estimated that 40–70% of healthcare in sub-Saharan Africa is provided by faith-based groups (WHO 2009).

¹¹ This includes dozens of local human rights, health- and faith-based organisations that join with international organisations such as Human Rights Watch and Global Witness to highlight the ongoing massive abuse of human rights.

¹² Note the importance of providing jobs for the large number of civilian unemployed as well as ex-combatants (Ohiorhenuan and Stewart 2008).

¹³ Rent economies are especially prone to poor democratic transition.

¹⁴ This means that women and marginalised groups are guaranteed representation.

¹⁵ Ideally, this should be done via mechanisms that co-brand donor with state support in order to enhance state legitimacy.

¹⁶ Civil organisations have historically been more state oriented in Brazil, and the Catholic Church has played a prominent political role (IDS 2005), underlying the importance of understanding country contexts.

¹⁷ For a fuller discussion of the effect of community participation in improving accountability, see S Commins, *Community participation in service delivery and accountability*, Jan 2007, Governance and Social Development Resource Centre. <http://www.gsdr.org/go/display&type=Document&id=2911&source=bulletin>

¹⁸ Principle 6 DAC Principles for good international engagement in fragile states

¹⁹ NB The study was accompanied by healthcare-strengthening activities in both control and intervention areas.

²⁰ Capability is the expertise and capacity of human/social capital. For a fuller discussion on Sen's capability approach and the enabling environment used in a conceptual framework for poverty reduction, see *Human Rights and Poverty Reduction: a conceptual framework*, OHCHR UN 2004, and more specifically for the health sector, see *Human Rights, Health and Poverty Reduction Strategies*, Health & human rights publications series, No 5, December 2008, WHO, OHCHR

²¹ That is, 'combining wrath and reason' (Sen 2009), which refers to the writings of enlightenment social philosopher Mary Wollstonecraft.

²² At that time 90% (two million) of the population of Gulu, Kitgum and Pader districts were living in camps, after a government policy of moving people into camps in 1997 so that ostensibly the Uganda People's Defence Force could be more effective in combating the LRA militia. The LRA continue to kill, maim, rape and terrorise villages in north-east DRC, and move between the DRC, Central African Republic and Southern Sudan.

²³ MSF had recorded much lower death rates in camps they managed (in data from later in 2005).

²⁴ The HSR makes the highly questionable claim that during most wars 'nationwide mortality rates actually fall'.

²⁵ No reliable data is available from Ituri during that period. For an idea of the scale of the neglected humanitarian crisis, see a report written by the author: *Under fire: the human cost of small arms in the north-east Democratic Republic of Congo, a case study*, Oxfam, 2001, and for the scale of the killing see *Ituri: Covered in blood. Ethnically targeted violence in north-eastern DR Congo*, 2003, HRV, written by Anneke van Woudenberg.

²⁶ There was a firearm death rate of 22 per 100,000 in 2004. Compare this with a rate of 4 per 100,000 in the US, a developed country associated with relatively high rates of homicide compared with comparable OECD countries.

²⁷ Speculation as to the causes of these high rates includes high rates of poverty, unemployment and inequality, poor law enforcement, alcohol and substance misuse and exposure to abuse in childhood.

²⁸ Exceptional organisations have been created in violence-reduction campaigns, but these have not been mainstreamed into the health sector. These include the International Red Cross Society, Physicians for Human Rights, International Physicians for the Prevention of Nuclear War, the International Campaign to Ban Landmines and Médecins sans Frontières.

²⁹ In the US, the Centre for Disease Control and Prevention (CDC) set up a National Centre for Injury Prevention and Control in 1991 with the aim of reducing injuries and violence in the domestic context.

³⁰ See D Sethi et al, *Guidelines for conducting community surveys on injuries and violence*, 2004, WHO.

³¹ See Liverpool John Moores University's Violence Prevention Evidence Base, supported by WHO and the Violence Prevention Alliance, although the cited studies address domestic violence and not conflict and war: <http://www.preventviolence.info/>

³² This coordinates the International Action Network on Small Arms.

³³ See the Assessment website: <http://www.timor-leste-violence.org/>

³⁴ These data provided a longitudinal analysis of victimisation, but were not sufficiently robust to make conclusions about the nature of interpersonal violence in the country.

³⁵ Among the most important was the 1948 UN Declaration of Human Rights, General comment 14 of article 12 of the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child.

³⁶ UNITAID is not an abbreviation. It is an international drug purchasing facility established in 2006 to scale up access to treatment via innovative financing. It is supported by 44 countries and the Gates Foundation and is hosted and administered by the WHO.

³⁷ Ooms also refers to this as 'ongoing reciprocal solidarity' (Ooms 2009).

³⁸ A summary of the evidence is not reproduced here but is provided by McPake et al 2008 and Yates 2006. Yates describes an imagined 'Kenzamia Health Services Inc', whose job is to increase consumption of health services. In the face of only a 2% contribution from direct customers the company decides to make their services free, which leads to soaring sales! In Uganda, when user fees were scrapped, outpatient attendance at government health units increased by 155%.

³⁹ See S Harrigan, *The cost of being poor: Markets, mistrust and malnutrition in southern Niger 2005–2006*, Save the Children UK, 2006, for an analysis of the crisis.

⁴⁰ See République du Niger Décret 2005-316/PRN/MSP/LES 11.11.2005 & Arrêté 65/MSP/LCE/DGSP/DPHL/MT 7.4.2006

⁴¹ This view, however, needs to be balanced with other facts, such as the misappropriation of the Global Fund budget in 2007 and the arrest of the Health Minister on corruption charges.

⁴² Ideally, this should be to promote a 'whole of government approach' that breaks down the institutional and budgetary walls between government departments. See *Whole of government approaches to fragile states*, OECD, 2006.

⁴³ Some of these resources come from remittances sent from family members overseas. An estimated \$1bn flows into Somalia each year in the form of remittances.

⁴⁴ For an in-depth analysis of how taxation can be promoted by the health sector, see N Briki et al, *Health financing – achieving universal coverage in low-income countries*, Save the Children UK, 2010, forthcoming.

⁴⁵ Stabilisation can be seen as interventions aimed at: i) preventing, stopping or reducing violent conflict; ii) protecting people and institutions; and iii) preparing for peace (DFID Somalia 2010). The definition often includes the promotion of political processes and development (Stabilisation Unit 2008), but it could be argued that these might sit more appropriately under a state-building framework.

⁴⁶ Len Rubenstein (2009) argues that resources for health reconstruction should be transferred from the US Department of Defense to civilian agencies.

⁴⁷ The military term used intentionally here refers to an environment in which it is too dangerous for unescorted civilians to operate.

⁴⁸ Commins (2009) refers here to Nepal, where decentralisation efforts by government in the 1990s were not accompanied by allocation of sufficient resources or revenue mechanisms.

⁴⁹ Scott observes that political economists are divided in their analyses as to whether decentralisation mitigates or exacerbates conflict.

⁵⁰ A World Bank review there in 2004 found that government clinics had an average of eight sources of cash income and 34 operational budgets (Commins 2009).

The Role of the Health Sector in Wider State-Building

A discussion paper

Fragile states are home to 15% of the world's population, but these states carry a disproportionate burden of maternal and child mortality and morbidity, with nearly half of child mortality, one-third of maternal deaths and one-third of undernourished children.

Recently, there has been increasing discussion about the role of the health sector in wider state-building. This paper explores six areas where the health sector contributes to wider state-building: human resources, service delivery, accountability, monitoring, global health initiatives and resource allocation. In addition, state-building is addressed in two contexts – decentralisation and stabilisation.

The paper concludes that health sector interventions, whether intended or not, always affect the interaction between citizen, service-provider and policy-maker, and therefore international partners should aim to reinforce, and not undermine, state resilience through these interventions. Well-designed interventions can build up sub-national capacity and support democratic processes of public reasoning and consent-building. The health sector needs to identify how more coherent programming and better governance can bring improved health status and can create more robust systems to reduce inequalities, destitution and fragility.