

Fragility and/of health systems: what are the stakes in the current changing aid landscape?

Possibilities for a common research & knowledge sharing agenda

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Setting the scene

- **Belgian ministerial declaration** (Nov 2014)
- **Policy note** on fragile settings (Jan 2013) + tool box
- ‘Tailored’ policies for fragile contexts by global health initiatives: GAVI (2012), GFATM (June 2014)
- Trends within politics of aid reform (UK, Denmark, Belgium, Netherlands, Canada)
 - Focus on fragile settings by bilateral agencies
 - Reduction in number of partner countries
- Poverty diminishes globally (no. of LIC) but not fragile settings £(ODI, 2012)



Aid reform

Drive for **aid reform**: SDGs, ebola outbreak, rising inequalities – new vision on aid

- Ebola outbreak is sobering
 - Sierra Leone & Liberia received UK aid for human resources for health (but the aid was cut)... What happened?
- GDP growth leaders in SSA (Ghana, Tanzania, Rwanda)
 - Weak link between growth and improved skilled service delivery despite considerable increase in revenue (2009-2011)



Aid reform: example UK

ODI report (Feb 2015)

- ‘Beyond health’: structural causes of ill health
- Results-oriented: yes, but defined as process

UK House of Commons (Feb 2015)

- Focus on development & security nexus through a ‘whole of government’ approach
- ‘Beyond aid’ issues: global health, climate change, migration, urbanization, peace & stability
- Policy coherence (DFID / Min of Foreign Affairs / Min of Defence)
- Mix humanitarian, development aid and conflict prevention



Why focus on fragile settings?

State-building in fragile states is showing cracks

“We do not have good evidence that technical assistance to governments will lead to better decision-making and has a positive impact on resources”

“We do not have evidence that working through faith based organisations (for health service delivery in SSA) is better than through INGOs”

(DFID, 2010)

Many unknown unknowns ...

Many doubts ...



Why focus on fragile settings?

Bilateral agencies: focus on **institutional development** & public sector reform

- Government & sector ministries: planning, HR, public financial management
- Decentralization: bringing government closer to the citizen would improve service delivery and accountability
- But: no immediate link between legitimacy state and its performance in service delivery
 - Ghana: good governor & donor darling, but failing to deliver on MDG 5

Bilateral agencies & INGOs: focus on **capacity building**

- Based on the assumption that capacity is the main barrier, while the key role of political commitment was ignored



Why focus on fragile settings?

Increasing critique on state building approach

- **Iso-morphic mimicry** (Andrews, Pritchett & Woolcock, 2010)
 - On the surface: **organisational change**, but **only skin-deep**
 - Structures are changed, organisational culture does not change
- Focus on states as singular entities: no longer effective
 - Ignoring the fluidity between state, market and civil society in fragile settings
 - Differences in legitimacy between central level, regional and local authorities



Why focus on fragile settings?

Current change of discourse: from **fragile states** to **fragile settings**

- **Deterritorialization**: border regions, mining sites
- Governance **‘from within & from below’**
 - hybrid governance, interactive, democratic network governance, good enough governance, ‘upside down approach’



Why focus on fragile settings?

Where the state does not play a role in public service delivery, the vacuum is filled by other actors

- This default ‘solution’ will not be optimal for everyone (privatisation, clientelism, devolution: growing inequity, lack of accountability) and might increase fragility
- Role of the state: even if absent, the state still has **symbolic power** (Bwimane, Secure Livelihoods Research Consortium)



What is a fragile health system?

A health system is fragile if it is not capable of absorbing shocks

- Shocks
 - Sudden events (natural disaster) / protracted crises (civil war)
 - Localized (cholera) / generalised (political instability)
- Chronic or protracted crises
 - Structural violence, political instability, rural flight,...
- The “fragility” of certain health system components impacts on the system as a whole
 - Complex nature of health systems (Weak governance in Eastern Cape Province – effect on service delivery)



What is a fragile health system?

Fragility of health systems is embedded in

- fragility of communities & individuals
 \cong human security: different types of insecurity
 - food, economic, health, personal, community, political and environmental insecurity
- fragility of (the) governance (context)

Different configurations of fragility in different settings



Determinants of fragility

Communities

Made fragile by

- Chronic political instability
- War, ethnic violence, sexual violence
- High competition for scarce resources (extraction economy)
- Large scale / rapid migration
- Extreme poverty
- Destruction/exhaustion of natural resources



Determinants of fragility

Governance: multiple actors, multiple levels & interfaces

- Confused responsibilities of different levels
- Lack of dialogue and negotiation between multiple 'governing' actors
- State only has symbolic power (absent in public service delivery)
- No recognition of role of state in steering health service delivery
- Rent seeking, political patronage
- Mimicked decentralisation



Fragility as a concept

- Still confusion
 - Food for thought for this meeting



How to operationalize fragility in health system strengthening?

Paradigm shifts

- from **providing solutions** to **solving problems**
- from **static measurements** and tools taking the state as singular entity (e.g. SGACA, CPIA tools; Fund for Peace) to **dynamic analysis & scenario-building** (cfr. 'states in transition')
- From **ideal-type** state-building as programme design to **best fit** (with context)
- From **fixed plans** to **flexible, adaptive interventions**
 - E.g. rural and urban health systems have different patterns of fragility and a different context (see RDC presentation)



How to operationalize fragility in health system strengthening?

Paradigm shifts

- From the planner to the negotiator / broker
- From a programme approach towards different types of aid modalities in tune with the pace of change
 - Flexibilize financing modalities
- Be brave: learn to deal with uncertainty
- From prescribing solutions to trial and error approach
 - ‘Flexible and Forward Decision-making’
 - ‘Problem-Driven Iterative Adaptation’
 - ‘Realist Evaluation’: iterative testing and refining of initial assumptions



How to operationalize fragility in health system strengthening?

Paradigm shifts

- Take **politics** into account (actors and their interests - political economy)
 - Work with incomplete decentralisation as a given
 - Maldistribution of HRH is more than a technical problem
 - compounded by **rent seeking** (patronage)
 - Service delivery is subject to **elite capture**
 - Sexual violence is a political instrument of war to demoralize the population



How to operationalize fragility in health system strengthening?

Conditions

- Need for better knowledge generation & sharing
 - Organisational adaptation and learning
 - Systematic exchange between organisations and actors
 - Need for more research using appropriate approaches



In summary:

Problem-driven iterative analysis & local problem-solving

1. Diagnosis: causal analysis of determinants of fragility (including the governance context)

2. Analysis of default equilibrium / solution

E.g.: when State does not deliver health services, other actors take its place

- Which actors are really delivering services?
- This hybrid space is ‘patchy’ - not a guarantor of quality service delivery nor of access and equity



In summary:

Problem-driven iterative analysis & local problem-solving

3. Working incrementally towards a strategy to attenuate fragility

- Actors and interests: Who wins? Who loses? What is the effect on public accountability?
- Which enabling context conditions?
Work across state & non-state actors
- Work across all levels & interfaces
 - LHS is a ‘globalized’ space

4. Continuously learn and adapt the strategy based on feedback and iterative analysis



Today's programme

1. Presentations

The **meaning of fragility** in health systems

- RDC presentation: different types of fragility in different provinces

How to translate principles on **fragility into strengthening of health systems** in fragile settings?

- Enrico Pavignani, Peter Salama

What are **enabling 'rules of engagement'** for donors?

- Innovative financing modalities - Peter Salama and Karel Gyselinck
- How not to fall into the trap of “best practices”?



2. Discussion – where do we go from here?

Discussion

- Fragilities (in plural): governance, SRHR
- How to operationalise fragility in HSS

Way forward

- Common research and knowledge sharing strategy?
- How to keep the dynamic alive?
- Research into policy?



Some practical issues

- Some changes in the programme
 - Dr. Masuka (MOH Zimbabwe)
- One presentation will be in French, but summary translation will be provided

