Conflict in least-developed countries: challenging the Millennium Development Goals

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Five years before the 2015 deadline for achieving the United Nations' Millennium Development Goals (MDGs), the picture on progress is mixed. Persisting challenges include dysfunctional health systems, gaps in reliable morbidity and mortality data, uneven progress between goals and growing inequity between subpopulations.[1–3]

Jan Vandemoortele, one of the architects of the MDGs, emphasizes that the MDGs are globally aggregated and "not meant as a uniform yardstick for measuring performance across countries".[4] Progress across regions and in individual countries varies with social and political structures, geography and local history. The impact of conflict cannot be underestimated: countries suffering conflict are also performing poorly in meeting their MDGs. One-third of countries with low human development are in conflict, with the impact spilling across borders into neighbouring regions.[5] Sub-Saharan Africa, the site of 40% of the world's major conflicts, suffered the highest direct death toll in the decade before 2000. The indirect health implications compound the situation with deaths from consequent disease and malnutrition. In 2008, there were an estimated 41.2 million internally displaced people and refugees globally.[3]

In these situations, more than any other, the context of MDG progress is critical: conflict disrupts health systems and other government institutions, compromises capacity and renders governance and the legitimacy of authorities uncertain. While securing peace is the main goal, building local ownership of the MDG process and mapping out locally effective programmes are important priorities within that process.[4]

Afghanistan provides an intriguing and, in certain ways, encouraging example: in 2000, the declaration of the MDGs was irrelevant to the (then) Taliban government and its patchwork of warlord allies. At 0.345, its development index – a composite of life expectancy, education and economic performance – ranked it 174th of 178 countries. Neonatal and infant mortality rates were high. Its maternal mortality ratio, with estimates ranging from 1600 to 2200 per 100 000 live births (6500 reported in Badakshan province), compared poorly with its neighbours.[6] Development assistance was minimal. Women were prohibited access to education. The health system was fractured and dysfunctional.

Then, in 2001, the "war on terrorism" brought Afghanistan to the centre of international attention. In the immediate aftermath of the defeat of the Taliban, the health systems vacuum was rapidly filled by international development assistance. Health services, provided by international civil and military agencies, developed without effective integration, sustained by project support in major population centres and lacking a coordinating policy framework or effective governance structures. There were early attempts to secure a strategic approach for development. In 2002, the *National development framework*[7] focused on the acute rehabilitation needs of the country. The 2004 document *Securing Afghanistan's future: accomplishments and the strategic path forward*,[8] while adopting a longer-term perspective, and arguing for more sustainable development of sectors including health, lacked Afghan engagement and a sense of local ownership.

In March 2004, the government appointed a high-level commission to adapt the MDG framework to the Afghan context. The commission was systematic in estimating the extent of attrition during the 1990s, and the constraints imposed by insurgency and lack of quality data. Acknowledging the disadvantages that Afghanistan faced, coming late to the MDG process, they courageously – and unilaterally – extended their MDG deadline by five years to 2020, and added a ninth goal: national security.

These "Afghanized MDGs" have been integrated into national planning processes, set as the monitoring framework for the Afghanistan National Development Strategy and reiterated in the "Afghan Compact", a partnership of donors, multilateral organizations and the government. Despite limited local resources and technical expertise, an unevenly distributed workforce and the challenges of managing multiple international agencies (including the military), the national government maintains its intention to coordinate interventions in health.

Progress against the MDGs has been uneven, but broadly positive: immunization rates against diphtheria, pertussis and tetanus have increased from 54% of infants in 2003 to 85% in 2008; mortality rates for children aged less than 5 years have reduced from 257 per 1000 live births in 2001 to 191 in 2006; infant mortality rates have reduced from 165 per 1000 live births to 129 in the same period. For complex social, geographical and political reasons, maternal mortality remains a challenge, though skilled birth attendance has risen from 14% in 2003 to 19% in 2007, and the massive increase in access to health services from virtually no coverage to 82% in 2006 provides a base from which to build further positive progress.

The case-study offers salutary lessons for progress towards MDGs. First, conflict must be addressed if progress is to occur: the context within which the MDGs are monitored is critical. In volatile settings, interim targets, with progressive review and extension, will be more effective in informing programme management than distant goals.[4] The assertion of ownership reflected in extending the deadline to 2020, and the addition of what it sees as an obvious and overlooked goal of security, has reframed the MDGs so that they serve local development, rather than sit in judgement on it. ■

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