From services to systems:
Entry points for donors and non-state partners seeking to strengthen health systems in fragile states

"It is my aspiration that health will finally be seen not as a blessing to be wished for; but as a human right to be fought for."

Former United Nations Secretary General, Kofi Annan

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Executive Summary

Effective and equitable health systems are not only required for achieving the Millennium Development Goals (MDGs), but strengthening health systems is essential if aid for health is to be well spent and sustained in the future. Health systems strengthening (HSS) is therefore high on the agenda of donors, governments and other stakeholders in the health sector, especially in fragile states, where the government is either not able or not willing to deliver core services to the majority of its people. In these states, the challenge to meet the health MDGs and provide the population with sustainable and equitable health services is far greater than in other developing countries. In these contexts, improving health service delivery not only stands to make significant gains in overall population health indicators, but also has the potential to contribute to reducing state fragility.

This study will seek to outline and synthesise known practices for HSS in fragile states, in order to provide an analytic look at the emerging effective routes, tools and applications of HSS practices at both the donor and operational levels. The key in fragile states is to find ways to effectively solve problems in a given context, which does not mean imposing a pre-determined solution or a "one size fits all" approach. It is up to the stakeholders in the host country health sector to determine local "packages" or general sets of interventions that can be pursued depending on what is locally required and feasible.

This paper uses the World Health Organization (WHO)'s Framework for Action as its analytic framework. The framework consists of six building blocks that can be used to guide planning and priority setting by actors supporting health system reforms, including those in fragile states. These building blocks set out the essential functions of a health system, are applicable across the continuum from humanitarian relief to sustainable development, and consist of (1) leadership, governance and (2) financing of health systems, as well as the strengthening of (3) health information, (4) service delivery, (5) human resources, and (6) medical and drug supply systems. Each one of the six addresses a cross-cutting function of a health system, so the building blocks complement and overlap one another.

Strengthening each of these building blocks can be accomplished through identifying a set of complementary activities that can be supported along the spectrum of humanitarian aid to sustainable development in which many of the fragile states find themselves. Irrespective of whether local conditions are improving, deteriorating, or whether they involve a protracted crisis, a country's levels of governance, local capacity and functional infrastructure will vary and these, more so than levels of conflict, will dictate which activities are more appropriate to implement.

There are venues where alignment and common approaches to aid in fragile states have emerged. The Development Assistance Committee of the OECD has been a lead centre for addressing issues related to fragile states, while the Inter-Agency Standing Committee has been central in the on-going engagement of donors and international non-governmental organisations (INGOs) in humanitarian reform. Both the fragile states work and the humanitarian reform efforts are among the efforts by donors to address obstacles to effective health services through both funding modalities and programming in the past decade.

There are significant roles for non-state providers (NSPs) that will differ depending on the nature of the fragile context, and the longer-term experience of NSPs in a given country or region. In protracted crises, NSPs provide the potential continuity of services and, depending on the context, can support capacity-building of MoH and/or local government. In deteriorating contexts, NSPs may be the only available functioning organisations for basic service delivery, but even in these contexts, investment in human resources and in some elements of governmental systems may be possible. In improving contexts, NSPs need to be part of a wider health systems approach, so as to avoid setting up parallel systems.

World Vision and other INGOs can contribute to HSS in a variety of ways, but frequently this contribution is dependent in part on public sector donors and their aid modalities. This fact underscores the importance of getting a common aid modality in place, so as to encourage shared assessments, policies and programs amongst public sector donors, international partners and national stakeholders. A well-functioning and common aid modality can help develop and support national HSS plans adapted to the country context using frameworks such as the WHO's building blocks. This aid modality can in turn promote further coordination and dialogue between donors, INGOs, government, and CBOs. Where possible, the longer time-frame required for strengthening health systems can be addressed in part through entering into longer-term agreements with donors and governments, using this aid modality. In order to contribute to greater downward accountability in fragile states, where feasible, World Vision and other NGOs should be encouraged to participate in common aid modalities to develop governance and capacity building strategies as part of HSS goals.

GUIDING PRINCIPLES FOR PRACTICE IN HSS

IMPLEMENTING HSS USING A COMMON FRAMEWORK

1. Use a common framework, such as the six WHO building blocks, to ensure that there are no "orphan sections" within the health system. All components are inter-related and vital, and all require support.
2. Be realistic. "Good enough governance" may actually be achievable, while good governance may be out of reach. Where service provision is characterised by inadequate and inequitable resources, low capacity and poor governance, as is often the case in fragile states, it is perhaps best to pursue modest ambitions for service delivery in the early phases of HSS. Reorganising health service delivery through a process of standardisation may be the best course of action to address structural constraints; for example this could be done via an essential health package, with specific considerations for the poorest and most vulnerable populations.
3. Planning should not only revolve around governments and donors. It is important to include the voice of civil society and communities. Planners should think in decades, not years, although these long-term plans should be divided into short-term, feasible steps and achievable targets to keep motivation levels high. Communicate plans widely.
4. It is easier to build a new house from scratch. However, in HSS in FS, a sincere effort to build on or incorporate existing foundations can result in higher levels of support, motivation and ownership from public sector than if an existing system and its staff are dismissed or ignored.
5. Do not be afraid of innovation. Working on HSS in FS offers a unique chance to try something new.

CREATING AN ENABLING ENVIRONMENT

6. Use a common framework and fragility assessment tools for analysing country context.
7. Adapt the donor aid architecture in ways that support the ability of both donors and NSPs to be flexible in specific fragile states and sub-national contexts.
8. If the government cannot be a partner, donors could create an external service delivery "cabinet" to provide a co-ordination mechanism, both by sector and for overall service arrangements, meanwhile encouraging continuing contextual assessment for future MoH support.
9. Donors, governments and NSPs need to pay more attention to the development of more robust and effective accountability processes, as these can contribute over time to the reduction of fragility as well as to improved health services.

Contents

Acronyms

ARTF	Afghanistan Reconstruction Trust Fund
BPHS	Basic Package of Health Services
CAF	Country Assistance Frameworks
CAS	Country Assistance Strategies
CBOs	Community-based organisations
CDD	Community-driven development
CDR	Community-driven reconstruction
CHW	Community health worker
CPIA	Country Political and Institutional Assessment
CSO	Civil society organizations
DAC	Development Assistance Committee
DFID	UK's Department for International Development
DHS	Demographic and Health Surveys
EPHS	Essential Package of Hospital Services
FBO	Faith-based organisation
GAVI	Global Alliance for Vaccines and Immunisation
HIS	Health information system
HIV & AIDS	Human Immunodeficiency Virus & Acquired Immune Deficiency Syndrome
HMIS	Health management information system
HR	Human resources
HSS	Health systems strengthening
IDPs	Internally displaced populations
INGO	International non-governmental organisation
LICUS	Low-income countries under stress
M&E	Monitoring & evaluation
MDG	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MICS	Multiple Indicator Cluster Surveys
MoH	Ministry of Health
MoPH	Ministry of Public Health
MTEF	Mid-Term Expenditure Framework
NGO	Non-governmental organisation
NSP	Non-state provider
ODA	Overseas development assistance
OECD/DAC	Organisation for Economic Co-operation and Development – Development Assistance Committee
PBA	Programme-Based Approach
PHC	Primary health care
PRSP	Poverty Reduction Strategy Papers
RUD	Rational Use of Drugs
SWAp	Sector-Wide Approach
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Framework
WGA	Whole of government approaches
WHO	World Health Organization
WV	World Vision

1   Introduction

The creation of strong health systems is not an end in itself – it is a means to achieve better health outcomes for populations. Effective and equitable health systems are not only required for achieving the Millennium Development Goals (MDGs), but strengthening health systems is essential if the current increase in aid for health is to be well spent and sustained in the future. Health systems strengthening (HSS) is therefore high on the agenda of donors, governments and other stakeholders in the health sector, especially in fragile states.

At the same time, the challenge to meet the health MDGs and provide populations with sustainable and equitable health services is far greater in fragile states than in other developing countries. Yet improving health service delivery in these contexts could not only lead to significant gains in the overall health of a population, but also has the potential to contribute to reducing state fragility. Conversely, long-term improvements in health service delivery, such as regular delivery of basic services at the local or community levels of the health system, will only occur with changes to the fragile context of the services.

Thus, there appears to be general agreement amongst the relevant actors that HSS is an essential undertaking in fragile states, although general knowledge on how to do it remains in its infancy. Furthermore, due to the restrictions within current financing mechanisms and coordination challenges in fragile states, donors and other actors still tend to focus more on piece-meal, project-based service delivery, rather than on HSS. In order to address these challenges, this paper seeks to stimulate discussion and debate among stakeholders on how to take HSS in fragile states forward. It aims to outline and synthesise known practices for HSS in these contexts, and where possible, will provide an analytic look at the emerging best routes, tools and applications of HSS practices at both the donor and operational levels. The World Health Organization (WHO)'s six health systems building blocks are used as a framework to explore what concrete steps health ministries, non-state providers (NSPs) and donors can advocate for, implement or support across the humanitarian relief-to-development continuum. Additionally, as HSS also requires strong aid mechanisms to support work within these six building blocks, the paper will provide a related overview of key questions related to aid mechanisms and the role donors can and do play in HSS.

Because the nature of fragile states profoundly shapes the ways in which the lives of children, families and communities can be changed in the short and medium term, understanding fragile states and the emerging discussions around HSS in these contexts is important for World Vision, other international non-governmental organisations (INGOs) and non-state providers (NSPs) more generally. It is also important to donors, since the ways in which donors define fragile states shape the ways in which they can choose to fund or not fund specific programmes such as HSS – including where to target support along the continuum of care from home to hospital, the levels of funding allocations, and the associated coordination/harmonisation mechanisms. This is in turn reflected in what health ministries and NGOs can actually achieve in HSS, and more importantly, what they can achieve in improved health outcomes. For all these reasons, it is critically important to better understand how HSS can be undertaken in fragile states.

The concepts of fragile states and HSS come with their own sets of terminology and theoretical frameworks. In order to give the reader who has little or no experience with HSS in fragile states a brief theoretical foundation and some familiarity with the frameworks used in later sections, the following subsections will provide a short overview of current thinking

on these and related concepts. This section lays the foundation on which a number of the recommendations in this paper will be based, and also outlines the aims, objectives and structure of the paper.

1.1 Defining and understanding fragile states

Fragile states are generally defined as states that lack the capacity and/or the will to provide for the wellbeing and security of their citizens.[1] According to World Bank estimates, they are home to only 9% of the developing world's population, while they account for 25% of the population in extreme poverty[2].

Many development partners have an organisation-specific listing or categorisation of fragile states based on various parameters, including risk of conflict, accountability of government institutions, capacity to manage public resources and deliver services, degree to which state institutions have control over their territory, levels of poverty, and the government's ability to protect its poorest citizens. Many countries do not wish to be labelled as fragile states, therefore donors do not commonly publish the lists of states that they define as "fragile", but there is one particular list that is made available, and therefore it is commonly referred to. This list is published by the World Bank[3], which assigns a "fragile state" classification to a country if it is (a) in the bottom two quintiles of the Country Political and Institutional Assessment (CPIA) rating, which assesses governance and a country's ability to use development aid effectively; or (b) has not been rated by the World Bank. All eligible countries are low income states, and each year, the list is revised, so that fragility is defined based on a spectrum of factors, reflecting a time-specific situation and not a permanent condition. Until recently, fragile states were known in the World Bank as low-income countries under stress (LICUS).

Fundamental to all fragile states is the lack of effective political processes to influence the state to meet social expectations, reflected by weak institutions and governance systems. Most fragile states experience at least short-term conflict, but not all fragile states experience endemic violence. All suffer from poor governance and limited administrative capacity[4]. The often-quoted UK government definition for fragile states encompasses many of these characteristics, and reads: "those states where the government cannot or will not deliver core functions to the majority of its people, including the poor"[5].

Fragile states have also been classified into different typologies. One often-used typology consists of three categories describing the general political stability of a state: (1) "weak but willing" where government capacity is an obstacle to implementing policy; (2) "strong but unresponsive" where state capacity is directed to achieving development goals; (3) "weak-weak" where both state capacity and political will are lacking.[6] A second typology consists

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[1] DFID, "Why we need to work more effectively in fragile states," (London: Department for International Development, 2005).

[2] World Bank, "Global Monitoring Report 2007," (Washington, DC: World Bank, 2007).

[3] http://siteresources.worldbank.org/EXTLICUS/Resources/511777-1269623894864/FS_List_FY11_%28August_8_2010%29.pdf

[4] Alina Rocha Menocal, Timothy Othieno, and Alison Evans, "The World Bank in Fragile Situations: An Issues Paper," in *An Eye on the Future: the World Bank Group in a Changing World* (Amsterdam Overseas Development Institute, 2008).

[5] DFID, "Why we need to work more effectively in fragile states," 2005

[6] M Moreno Torres and Michael Anderson. "Fragile States: Defining Difficult Environments for Poverty Reduction", (DFID, 2004).

of: (1) prolonged crisis or impasse; (2) post-conflict or political transition; (3) gradual improvement; and, (4) deteriorating governance.[7] Irrespective of the typologies used, it may be difficult to categorise an entire country, as parts of the country may be stable and relatively peaceful (i.e. post-conflict), while active conflict is confined to a specific area (i.e. deteriorating governance in that particular region). In this paper, we will not focus on specific typologies to a great extent. Even amongst countries suffering from a protracted crisis, for example, health systems can be vastly different and HSS will require different approaches. Within each context, additional dynamics such as the impact of greater levels of violence or shortages of specific cadres of health staff, for example, can influence priority-setting for HSS.

Many fragile states are post-conflict countries, which tend to suffer from high rates of relapse to conflict, with an approximately 40 per cent chance of a return to conflict within five years[8]. Conflict has very severe effects on economic growth; therefore most conflict-affected fragile states have growing levels of extreme poverty, which is opposite to the trend in most low income countries[9]. Current thinking amongst UN agencies, donors, and governments in Western countries tends to integrate the concept of "peacebuilding", which purports that security and development are interconnected, and "whole of government approaches" (WGAs). The WGA concept asserts that building national and local institutions in a fragile state can help provide a new government with the credibility and popular support it needs to prevent a country from sliding back into conflict[10].

Donors have recognised that fragility has a major, negative impact on service delivery, reflecting several factors.[11] These factors include: loss of financing for services; increased social insecurity due to violence; exclusion of disempowered groups; endemic corruption; and the failure or misuse of security and justice systems. In fragile states, there also can be specific problems with skewed budget allocations that favour particular ethnic or religious groups—along with systematic exclusion of women, minorities, and disabled individuals—which undermine the foundations of public service delivery systems.

Federal States and Sub-national fragility

It is important to emphasise that fragility does not always apply at the level of an entire federal state. As noted previously, at times pockets of fragility exist within a fairly stable national governance system. Sub-national fragility occurs in countries where there are significant differences between parts of a country in terms of governance, government capacity and levels of violent conflict. Examples include Aceh and West Papua in Indonesia, the Federally Administered Tribal Areas (FATA) and Balochistan in Pakistan, the Maoist areas of India, and Northern Uganda. This paper therefore also applies to fragile contexts, and not only fragile states, as many of the same needs for reconstruction will exist whether one is

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[7] World Bank, "Fragile States--Good Practices in Country Assistance Strategies", (WB, 2005).
[8] Paul Collier et al., "Breaking the Conflict Trap: Civil War and Development Policy," (World Bank and Oxford University Press, 2003).
[9] Paul Collier, *The Bottom Billion. Why the Poorest Countries are Failing and What Can Be Done About It* (OUP, 2007).
[10] UNDESA Task Force on Peacebuilding and Development, "Developing a Strategic Framework for UNDESA's Work on Peacebuilding: A Plan of Action" (UNDESA, 2008).
[11] Catherine Dom, "FTI and Fragile States and Fragile Partnerships," EFA/FTI (2009); Andrew Cassell, "Health in Fragile States: An Overview Note," High Level Forum on the Health MDGs (2005).

dealing with a national or local government body, and the terms "fragile states" and "fragile contexts" may, at times, be used interchangeably.

1.2 WHO's six health systems building blocks

In addition to the concept of fragile states, this paper also introduces the concept of health systems strengthening (HSS). HSS is a broad concept, and there is no single set of best practices that can be put forward as a model for improved performance in every context. WHO, in an effort to fill this gap, developed the *Framework for Action* which consists of six building blocks[12] that can be used to guide planning and priority setting by actors supporting health system reforms. These building blocks outline the essential functions of a health system. They apply across the continuum from humanitarian relief to sustainable development, and they consist of (1) leadership and governance; (2) financing of health systems; as well as the strengthening of (3) health information; (4) service delivery; (5) human resources; and (6) medical and drug supply systems. Since each addresses a cross-cutting function of a health system, the building blocks complement and overlap with one another. In order to achieve HSS, each of these six essential functions of a health system needs to be addressed. These building blocks will serve as the backbone of this paper and are covered in depth in Section 2.

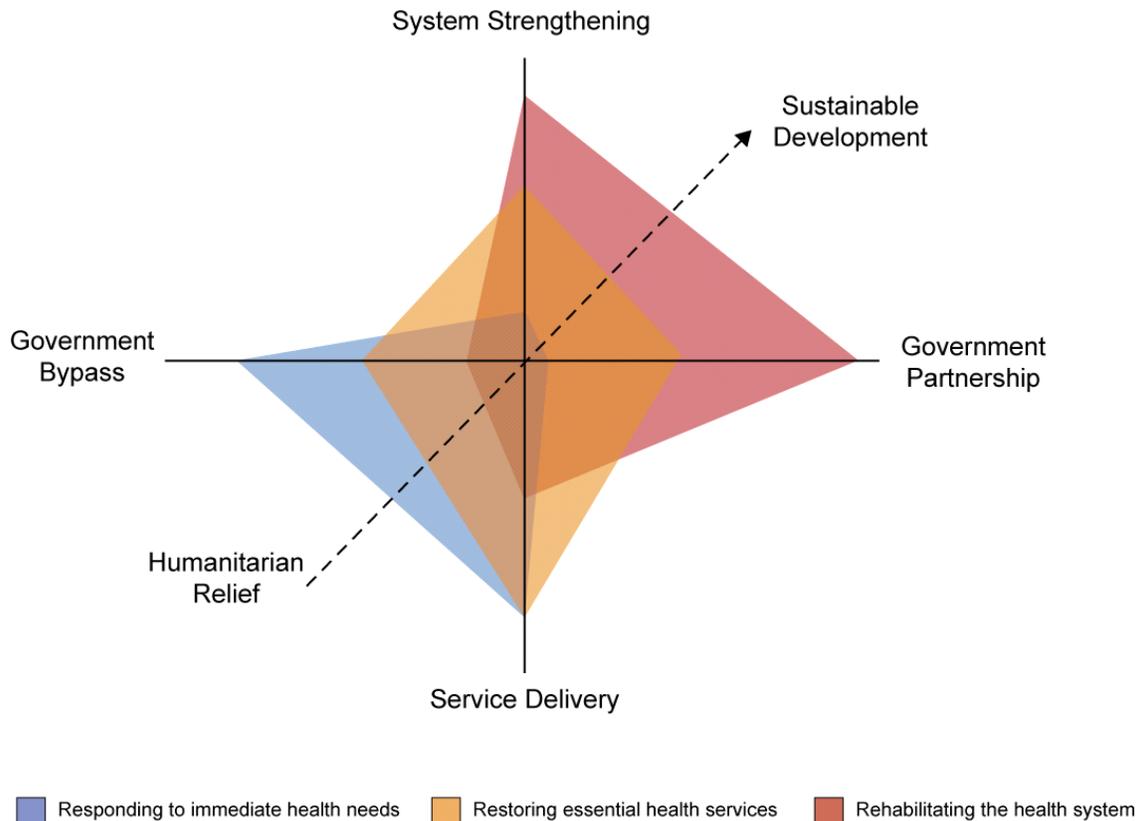## 1.3 The continuum from humanitarian relief to sustainable development

In fragile states, where governments are ineffective either due to incapacity, lack of will or prolonged conflict, agencies with a clear humanitarian mandate are generally found to be at the forefront of health services delivery. They generally can - and do - bypass government structures in order to rapidly establish services aimed at saving lives. At the point where the government indicates that it will resume some form of control, humanitarian agencies gradually make way for other non-governmental agencies with a more development-oriented mandate, or may otherwise shift their own programming models. This second group of agencies will fill existing health services gaps, but for the most part, their ultimate goal is to achieve sustainable development. They seek to support health systems strengthening through partnering with the government and providing technical assistance, rebuilding infrastructure, providing health services through contracting-out mechanisms (where governments and/or donors contract services provision out to private providers such as non-governmental organisations rather than doing it themselves) and in some cases, by assuming advocacy roles at local and international levels.

The continuum from humanitarian relief to sustainable development is outlined in Figure 1, below. There are two important points worth noting. First of all, this continuum is not unidirectional – the types of interventions in a given context can shift from a developmental to a humanitarian perspective as well as vice-versa. Zimbabwe, for example, was a model of sustainable development in the 1990s, but it slid rapidly down the continuum. During the past decade, the work of international agencies there has increasingly shifted from development to humanitarian assistance, and with recent political changes, may shift towards the development perspective once more. The second point to be considered is that there is no activity that belongs exclusively to a given scenario. Although it is logical to progress from saving lives to restoring essential services to rehabilitating the health system, in reality all types of activities can occur simultaneously, with levels of each activity dependent on the

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[12] World Health Organization, "Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action," (Geneva: World Health Organization, 2007).

local context. For example, acute emergencies often result in an opportunity for change that otherwise might not have existed. Conflicts are generally expected to end eventually, and such contexts where "the end is in sight" are highly suitable for starting to take steps towards HSS. Haiti is a good example of an acute emergency leading to HSS, while Mozambique is a good example of a health ministry being ready for the signing of peace agreements in order to commence with health reforms.

FIGURE 1. INTERVENTION TRANSITIONS TO SUSTAINABLE HEALTH SYSTEM DEVELOPMENT[13]

The framework in Figure 1 illustrates that there is considerable overlap between activities that are implemented at various stages along the humanitarian relief-to-development continuum. It is therefore not truly feasible to clump activities together into three clearly distinct intervention targets (i.e. according to the three categories of activity outlined at the bottom of the figure). Although Brinkerhoff does use these three categories in his theoretical work, they will generally not be adopted in this paper. Instead, we will use a simpler approach of roughly ranking activities along the humanitarian relief-to-development continuum.

Similarly, as fragility is not a static concept, WHO's six health systems building blocks cannot be broken down into distinct sets of activities for each of the typologies of state fragility described in Section 1.1. All fragile states differ in terms of the duration and type of fragility experienced, the type and level of development achieved prior to the onset of

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[13] Derick W. Brinkerhoff, "From Humanitarian and Post-conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs," (HealthSystems20/20, 2008).

fragility, and the amount of government control retained during the crisis. There are no two fragile states alike. A fragile state such as Somalia may be at the humanitarian relief end of the spectrum, but UN health bodies, serving almost as a proxy health ministry, are working with NGOs, communities, fledgling civil society organisations, local authorities, and government representatives to develop and implement a national package of essential health services, which would give any functional central government a head-start towards systems strengthening. Throughout the period of conflict, the Health Ministry in Nepal continued to support the health facilities they had previously established, but in protracted crises like Afghanistan most support from government to health facilities ceased to exist. Zimbabwe has a well-educated population and has retained some form of a health system throughout its period of fragility. Most health clinics in Sierra Leone were established by the government before the war, but after the war many were run down or destroyed, so today are run by the MoH with support from NGOs. It cannot be stressed too strongly that the models adopted in this paper primarily serve a theoretical purpose, and that in each context local priorities and (quality of) resources will dictate what is possible to implement in terms of HSS.

Although there is no universally-applicable blueprint for HSS in all fragile states, a number of tools and models have been developed that can be introduced at different stages along the relief to development continuum, again, according to the local context. Section 2 of this paper will outline a series of activities that can be implemented (depending on where a state falls along this continuum) for each of the six WHO health systems building blocks. Establishing a linear planning approach, where relief-oriented interventions are gradually replaced by development-oriented interventions, as suggested by Brinkerhoff's model[14], could help stagger activities and keep the HSS process manageable, although certain interventions can be implemented simultaneously as well. If opportunities for specific activities arise "at the wrong time" in the planning process, those opportunities should nevertheless be seized if the conditions are right. For example, there is no reason why an INGO cannot choose to establish a revolving drug fund in the absence of a functional government if the possibility arises, as this could provide a head start in the effort to strengthen national supply systems.

1.4 Aims and objectives of this paper

As stressed in the previous sections, HSS in fragile states is a complex undertaking. At present, actors in the health sector still seem to rely upon a piece-meal, project-based service delivery approach rather than a coherent, system-strengthening approach. The key in fragile states is to find ways to effectively solve problems in a given context, which does not mean imposing a pre-determined solution or a "one size fits all" approach. It is up to the stakeholders in the local health sectors to determine local "packages" or general sets of interventions that can be pursued depending on what is locally required and feasible.

In order to stimulate discussion and debate among stakeholders on how to take HSS in fragile states forward, this paper aims to provide an outline and synthesis of known practices for HSS in these contexts, and where possible, will provide an analytic look at the emerging best routes, tools and applications of HSS practices at both the donor and operational levels. Care has been taken with the evidence offered, as "anecdote equals evidence" is too often the case; both donors and NGOs frequently prefer to tout their successes, rather than highlight their weaknesses or failures, although the latter can offer wise lessons.

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[14] Derick W. Brinkerhoff, "From Humanitarian and Post-conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs " (HealthSystems20/20, 2008).

Specific objectives for this study include the following:
1. To provide an introduction to concepts and frameworks related to health systems strengthening in fragile states.
2. To explore practical activities that NSPs, donors and other partners can undertake in order to support HSS in fragile states across the relief to development continuum.
3. To explore different aid models and practices which have been adopted by donors and governments in their efforts to create an enabling environment for HSS.

The first objective has been addressed in this, the introductory section of this paper. Objective two will be covered in Section 2, where the WHO's framework of six health system building blocks will be used as the backbone for the exploration of activities that health actors can support or implement towards HSS in fragile states. In this section, each of the six building blocks will be briefly introduced, followed by: a) a discussion of how it applies to fragile states; and b) a description of practical activities that NSPs, donors and other actors could implement or support in the process of HSS. Section 3 addresses the third objective, exploring how HSS can be facilitated through improved coordination and alignment between governments and donors, and the possible roles that NSPs can play in this. Section 4 will present a final set of conclusions and recommendations.

2   Supporting HSS: addressing the WHO's six building blocks

Fragile states face specific difficulties in all sectors of the health system, such as ensuring regular supplies of quality drugs, the recruitment and retention of qualified health workers, or the collection of reliable health statistics. The extent of these challenges, however, is likely to vary from state to state. Financing is another challenge, as the health sector is likely to be more expensive in fragile states than in other low-income countries, given that the health needs of a population or segments of a population in these contexts are generally higher while available human resources, material and infrastructural resources are fewer. Concrete data and sustained advocacy are needed, to stimulate stakeholders at all levels to respond to this reality. Additionally, there are challenges as to how to make the best use of all service providers – state and non-state alike – and how to generate a demand for services by citizens in environments where the health sector has performed poorly. In short, HSS in fragile states is as challenging as it is essential, and all partners in the process can make key contributions towards its progression. It is the intent of this section of the paper to present concepts and ideas that can inform the shape and form that such contributions can take.

Two common mistakes in HSS in fragile states, made by NSPs and governments alike, include (1) assuming that there is nothing worth salvaging from the previous system and (2) that it is impossible to make sense of the apparently chaotic form in which a previous or nascent system often presents itself. As a result, hasty decisions are frequently made based on incomplete or limited information, due to donor and/or public demands. Instead of this, concerned actors working in fragile states must carefully assess the existing health context, identify aspects of that context that could form a basis for their efforts towards HSS, and carefully manage the process through which HSS is to take place. It is also essential that they help all stakeholders (donors and the public) understand that universal service delivery is not achievable in a short timeframe, and clearly communicate where and how progress is being made. This kind of communication can help transform donor and/or public demands into essential support.

Especially in conflict and post-conflict settings, nascent health systems are increasingly being built up through formal collaborations between health ministries, donors and NSPs. The WHO's six building blocks can be used by these actors to ensure that all aspects of a health system are being supported at the policy, financial, technical and implementation levels. The following sub-sections introduce each of the six building blocks, provide practical insights into activities that can be implemented along the humanitarian-to-development continuum, and offer relevant examples and definitions. Each sub-section ends with a set of related recommendations. As has been highlighted previously, each fragile context is different, and it is for the local actors to decide which of the possible activities outlined here by individual building block is most essential and/or feasible to implement, or come up with other more feasible or appropriate alternatives. There is considerable space for innovation – the activities described here are generally open for adaptation to the local context, or can serve as a basis for new ideas and pilot projects.

2.1   Leadership and governance

Leadership and governance is the most crucial but also the most complex component of any health system. It is about the role of the government in health and its relationship with other actors whose activities have an impact on health. Weak leadership and poor governance are some of the defining characteristics of fragile states; health sector policies in these contexts are frequently ill-defined, while regulation and oversight in a weak and possibly corrupt system are not very effective. What roles, rules and practices should be established in order to build the public's confidence and trust in the ability of the reconstituted health ministry and other social welfare institutions to respond fairly and equitably to people's health needs, in particular to the poorest quintile of a population? And how should this be done? An increasing range of instruments and institutions have been developed to strengthen effective leadership, management and governance[15].

Due to the high levels of aid dependency and lack of technical expertise, governments and health ministries in fragile states generally rely heavily on donors, NSPs and civil society to collectively determine, inform and realise progressive health policies and regulations, as well as to strengthen national and local institutions for health. Government staff normally will end up carrying responsibility for stewardship of the health system in the long term, together with other ministries such as the Ministry of Finance. Additionally, parliaments and their committees, other levels of government, civil society and specific interest groups also play a role at central level, and their ability to fulfill this role will develop over time. But leadership and governance is needed not only at central level. Increasingly, and importantly, community groups also play a role in supporting the health system. They do this through participation in and support of local health committees working alongside health structures, ranging from health posts (generally staffed by volunteers from the village), to hospital management boards and, in some cases, provincial (or other sub-national) health committees. Additionally, formally elected representatives such as members of parliament can also play a role in representing the communities' voice at central government level. Where both strong

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[15] Catriona Waddington et al., "Towards Better Leadership and Management in Health: Report on an International Consultation on Strengthening Leadership and Management in Low-Income Countries," in *Making Health Services Work: Working Paper 10* (Geneva: Department for Health Policy, Development and Services, Health Systems and Services, World Health Organization, 2007); Derick W. Brinkerhoff and Thomas J. Bossert, "Health Governance: Concepts, Experience, and Programming Options " in *Policy Brief* (Washington DC: Health Systems 20/20, 2008).

community representation and strong leadership and governance in the health sector are present, the health sector stands to gain, and a strong health sector could lead to increased trust in the government and could potentially contribute to decreased state fragility. A project based approach by donors and NSPs fails to recognise this multi-stakeholder inter-dependence which is critical for governance reform, policy formulation and institution strengthening for HSS in fragile states.

None of the six health system building blocks represents a stand-alone activity. All elements of a health system overlap: in order to provide services, one needs human resources, finances, governance and supply systems. Leadership and governance, the building block discussed in this section, are functions that are optimised in the context of transparent and functional financing, supply and information systems. Coordination amongst all stakeholders is of the essence to ensure that all six health system building blocks are addressed, and that they can serve as a framework for planning HSS activities in any context.

2.1.1 Addressing leadership and governance along the relief to development continuum

It is vital to develop a long-term vision of a pro-poor health system from the start, even when donor and government efforts are focused on short-term measures to keep the health system going. Recent work has demonstrated the value of developing a strategic framework (a description of what the ministry stands for and what it wishes to achieve) and policies for the health sector as early as possible.[16] This is why, in the (early) reconstruction phase, health ministries should be assisted with the development of (sector) policies and medium-term expenditure frameworks for an equitable, standardised package of care that includes specific measures to reach the poorest and most vulnerable citizens. However, due to the urgency of these tasks, a clear plan for *institutional* organisation and strengthening to support the implementation of these services is often not drawn up until much later (i.e. the determination of clear lines of responsibility and communication within the health sector, including those for community engagement).

Given the contextual constraints inherent to fragile states (especially when conflict is ongoing) carrying out humanitarian, reconstruction and governance restoration tasks simultaneously is difficult. This complexity makes it essential that efforts towards governance restoration do not undertake unrealistic aims, but instead try to achieve what is necessary. Defining a standardised package of services could serve as a framework on which to further develop financing, supply, monitoring & evaluation, and human resource plans to ensure its delivery. These systems can then gradually expand with the expansion of services. Trying to achieve "good enough governance"[17] for the implementation of basic services is a sufficiently ambitious task in itself; it involves the balance between working towards that which is possible without losing track of that which is desirable.

Even if non-state providers continue to provide the bulk of health services, the state must play an active role in monitoring and regulating service provision and developing national health policy. This starts with a mapping of available resources as well as the main difficulties

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[16] Jack Eldon and D Gunby, "States in Development: State Building and Service Delivery". (HLSP 2009)

[17] Derick W Brinkerhoff and Ronald W. Johnson, "Good Enough Governance in Fragile States: the Role of Center-Periphery Relations and Local Government," in *4th International Specialised Conference "International Aid and Public Administration"* (International Institute of Administrative Sciences, Ankara, Turkey, 2008).

affecting health service delivery, which facilitates decision-making and makes it easier to identify key priorities. For example, lack of resources is sometimes so severe that if not addressed, other interventions become irrelevant. On the other hand, efforts aimed at strengthening national capacity are more likely to succeed if the basic components of a health system are in place and functioning[18]. Both political and technical expertise must be developed to help the state address competing demands for limited resources. This stewardship role of the health sector can be supported in various ways and at all stages of the humanitarian-development continuum as outlined in Figure 2, below. Agencies can independently support the strengthening of leadership and governance through one or more of a variety of capacity-building tools and approaches (green boxes). They can advocate for and/or take an active part in suitable platforms for multi-stakeholder collaboration and coordination (darker blue boxes) including giving the public a clearer mandate to participate in the health system (lighter blue boxes). Each of these types of activities is outlined in more detail in the following sub-sections.

FIGURE 2 –STRENGTHENING INSTITUTIONS
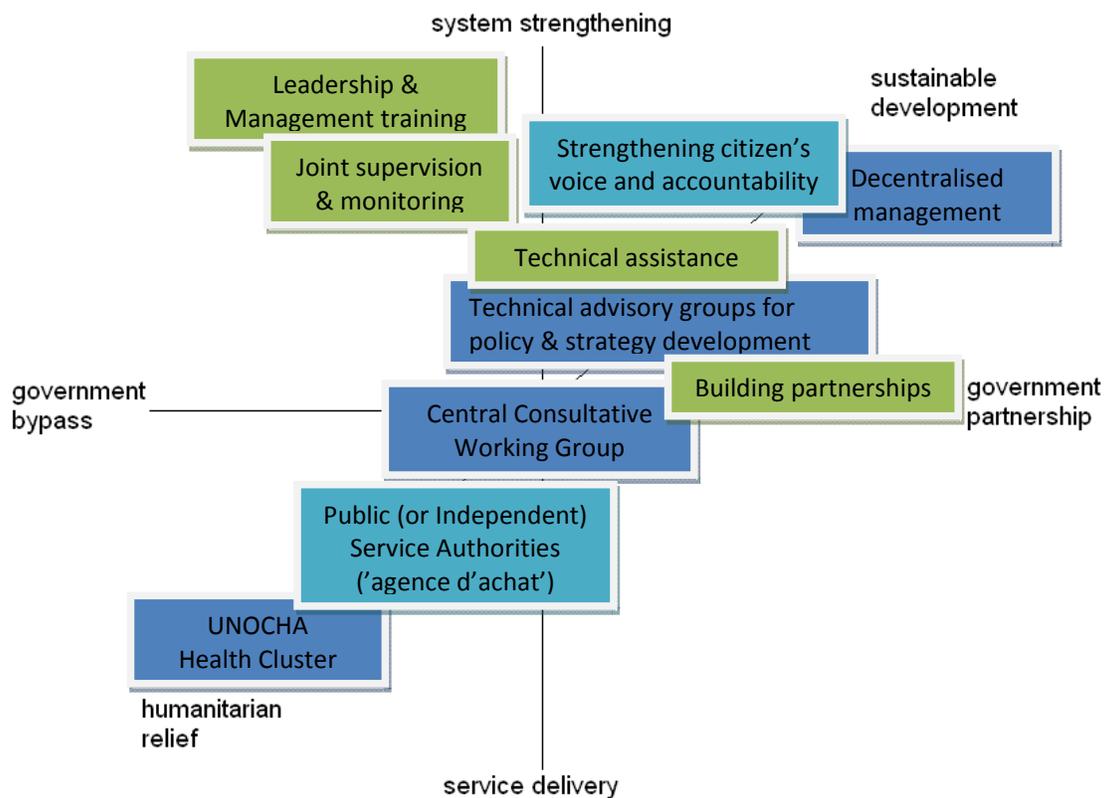
2.1.1.1 Tools and approaches for capacity building

Key components of effective health leadership and governance include policy guidance, health sector information provision/dissemination and oversight, collaboration and coalition building, regulation, system design, and accountability[19]. Efforts to strengthen health systems

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[18] Enrico Pavignani, "Health Service Delivery in Post-Conflict States." (2005)
[19] World Health Organization, "Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action." (WHO, 2007)

should address each of these components, and clear indicators and targets can be established to measure their attainment. A toolkit for assisting this process is available from the WHO website[20], and has been developed to assist in the Monitoring and Evaluation (M&E) process on the basis of the six health system building blocks also outlined in this paper.

An increasing range of tools and approaches have been developed to support or carry out the range of functions required for effective leadership, management and governance in health systems. Governance approaches, such as decentralisation, are generally weak or poorly developed in fragile states, and the capacity to implement or reinforce them is limited. An example of a useful tool is the clear delineation of national governance/health leadership and lines of communication through the development of an organigram for the health ministry. Its development can initially be seen as an unnecessary headache, since a continuous revision process often takes place in the early reconstruction phase, as roles and responsibilities (and names) of departments and units rapidly change in reflection of the expanding role and responsibilities of the Health Ministry. However, it is an essential tool to ensure that lines of communication are in place.

The paragraphs below give examples that demonstrate how capacity building activities outlined in the green boxes in Figure 2 can lead to improved leadership and management skills. The examples are by no means exhaustive, and additional tools and instruments can be found on relevant websites, such as those from WHO[21], the World Bank[22] and the Governance and Social Development Resource Centre[23].

Leadership and management training is often organised and provided by external technical experts. One example is the World Bank's flagship course on Health Systems Strengthening and Health Financing. These courses have their limitations as they are often theoretical and not always context-specific. Where leadership training is clearly geared to the local context, it can be particularly effective. An example of this is a locally developed and very practical training course provided to Provincial Health Directors (PHDs) in Afghanistan on subjects like planning, developing a strategy, developing and managing budgets – with the purpose of preparing them to take on the task of decentralisation to facilitate better access to primary level care. The curriculum was developed on the basis of a needs assessment conducted amongst the PHDs, where they were asked what skills and knowledge they felt needed strengthening in order for them to adequately perform their jobs. The drawback of this course was that the PHDs then rapidly moved on into senior management positions within the health ministry. However, by involving Ministry of Public Health (MoPH) staff in the planning and implementation of the training, and making all training materials available to MoPH, this facilitated them to continue teaching these courses to lower cadre provincial health staff.

Employment or secondment of technical consultants for HSS to the MoH is an option when local capacity in a specific sector is weak or non-existent. NGOs and UN agencies can help meet this need, or donors can make funds available for specific consultancy agencies to provide a team of experts. In all cases, a clear Memorandum of Understanding with the MoH is required. Although highly dependent on the capacity and experience of the individual consultants, technical support can contribute to the initial framing of key national policies and strategies that serve to strengthen the different elements of the health system. It can also help

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[20] http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Introduction.pdf

[21] http://www.who.int/management/en/

[22] http://info.worldbank.org/etools/wbi_learning/browse_lp_results.cfm?tb=prog&pronam=5

[23] http://www.gsdrc.org/

with the development and implementation of tools to support various elements of the health system.

Joint supervision and monitoring is a useful tool in contexts where the government retains control of health facilities, but lacks access to them due to funding or political constraints, or is unable to supervise them effectively due to a lack of technical expertise. This approach was successfully implemented in Timor Leste, where technical experts employed by an INGO joined regular supervision visits by public sector staff to provide support and training to address gaps in maternal and child health services delivery. In Afghanistan, provincial health staff and NGO staff also conduct regular joint supervision visits to health facilities as per the MoPH approved National Monitoring checklist. One provincial health director reported that by inviting other implementing agencies along, he was able to facilitate on-site exchange of lessons learned and best practices in a far more effective manner. In Nepal, government staff were unable to supply and supervise public health facilities due to ongoing conflict in some areas of the country. After gaining the trust of the local population through community meetings and negotiations, some national and international agencies were able to move around the conflict area freely and could transport public sector staff, supplies and funds, ensuring that health facilities remained functional, but also strengthening ties between the community and public sector staff.

More **formal partnerships** between INGOs and local NGOs, or between public and private service providers can also strengthen leadership and management structures at all levels and at all stages of reconstruction. Many local NGOs in fragile states were established through international NGOs, and were strengthened through continued partnerships with these INGOs. A considerable number have gone on to successfully implement health services packages. This is especially evident in Afghanistan, where most of the contracts for the Basic Package of Health Services are currently held by local NGOs.

Finally, by **investing in their own management structures and staff**, even during humanitarian crises – and especially in countries that are "aid orphans" and have been lacking donor support for long periods of time – NGOs often indirectly support the strengthening of local leadership and management capacity. In many post-conflict states, staff who took up leadership positions within health ministries were former UN or NGO employees who benefited from exposure to clear management strategies and internal training and capacity building. It must be noted that there is an inherent weakness in this approach. As mentioned previously, NGOs and UN agencies can drain public sector staff, especially in fragile states where qualified human resources are often in short supply. One approach that can be used to circumvent this, and which may be possible in some contexts, is formal secondment of public sector staff to an international agency, where the agency aims to integrate their programmes (including the management structures) into the public sector in the longer term.

2.1.1.2 Collaboration and Coordination Mechanisms

In fragile states such as Somalia, it is often UN agencies, donors, INGOs and technical consultants who provide critical support to domestic leadership and governance in a health system. In these, as in all fragile contexts, the most effective forms of leadership and governance are implemented through coordination mechanisms such as humanitarian clusters, coordination groups, and technical advisory groups, but these require strong and dynamic leadership from a single agency (or individual), supported by clear terms of

reference and time-delineated targets. It is essential to include a wide variety of actors in these bodies, such as ministry staff, NGOs, technical advisors, and where relevant, representation from related ministries. This said, humanitarian clusters may at times need to ensure a greater degree of distance from government in politically fragile or active conflict situations, to ensure greater neutrality. Examples of coordination mechanisms are described later on in this section.

Health systems are not exclusively about health ministries, their staff, and their implementing partners. The system is ultimately about the communities and individuals it seeks to serve, and a responsible and responsive health system should consider building up capacity and engaging civil society and the public to simultaneously improve leadership and governance from the local level all the way up, as well as from the top down. Public confidence in the system will increase with greater citizen involvement.

Humanitarian clusters are usually established by UNOCHA in fragile contexts. The **health cluster** is commonly hosted by the WHO country office and serves to coordinate all activities related to health services provision. Although these clusters originated from an expressed wish by NGOs for better coordination, some NGOs have chosen not to participate in the health clusters, and in many contexts a lack of strong leadership has made them largely ineffective. Nevertheless, these coordinating bodies, when able to pull together under strong leadership, can be instrumental in preparing for transitional contexts, and can function as a precursor to consultative bodies based in health ministries.

Public Service Authorities (PSA) were proposed as a model for health services delivery in fragile states by Collier and expanded upon in later work[24]. A PSA is a local authority responsible for allocating public funds to health service providers such as NGOs, faith-based organisations (FBOs) and the private sector, as a way to achieve objectives set by the ministries, while imposing yardstick competition on recipients. At present the closest example of a PSA may be observed in the "agences d'achat" established in the DRC and supported by Cordaid, which have seen some success in ensuring the delivery of basic health services.[25] Within these "agences", current efforts are being directed towards integrating funding streams and monitoring tools to improve their autonomy even further. The advantage of such an approach is that it fosters closer links between the health services and the communities that are being served.

A central consultative working group for health stakeholders such as the Coordinating Group for Health and Nutrition in Afghanistan, is established for the purpose of joint planning and decision-making, as well as information dissemination. It is chaired by the MoPH and includes NGOs, UN agencies, donors, and technical consultants. These bodies tend to be quite dynamic during initial planning processes, but as the MoH is gradually strengthened, more control likely goes to government bodies and less involvement of NGOs and other external stakeholders is generally required.

Technical advisory groups are subject-specific groups that address the need for policy and strategy development in key areas such as reproductive health, monitoring & evaluation

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[24] Tessa Bold, Paul Collier, and Andrew Zeitlin, "The Provision of Social Services in Fragile States: Independent Service Authorities as a New Modality," (Centre for the Study of African Economies, University of Oxford, 2009).
[25] Annemarie ter Veen, editor. *Health Systems Strengthening in Fragile Contexts: A Report on Good Practices and New Approaches.* (Health and Fragile States Network, 2009).

(M&E), and nutrition. These bodies are usually comprised of senior civil servants, local and/or international technical experts, and representatives from NGOs, UN agencies, related ministries, and other stakeholders who have an interest or expertise in the subject. Where these groups have a clear and strong leader, and a well-defined task description, they can be quite effective. Further, where national advisory groups can be supported by similar groups at regional and district level, situational analysis and information systems can be strengthened.

A decentralised public sector approach is thought to be conducive to appropriate and demand-oriented social services, and at times has also been promoted as a source of greater political legitimacy. Decentralisation has also at times been driven by local discontent with central government legitimacy. In some cases, moreover, it may be prompted by the need for the central government to rebuild services in weak or fragile contexts. A wide variety of factors have contributed to fragile states as diverse as Southern Sudan, Indonesia, Rwanda and Sierra Leone seeking to decentralise various public functions. Sri Lanka and Thailand are countries where the weakening of local government or of commitments to local autonomy by newly-settled national governments has contributed to lessened political legitimacy of the national state in minority regions. Structures for **decentralised management** include both symmetrical and asymmetrical systems, the latter frequently used to respond to the political demands of "excluded" regions. Decentralisation can range from the partial delegation of decision-making powers to a local (health) authority, to granting full autonomy.

Decentralisation generally occurs in contexts with a minimum level of stability, but preparatory steps can already be undertaken at the humanitarian end of the spectrum of interventions. One approach is through the establishment of a multi-stakeholder provincial or district level coordination committee, generally headed by the MoH, that is tasked with the joint monitoring of health services, planning for expansion of services, and the implementation of capacity building activities to support local leadership and governance in the health sector. Membership of this committee includes senior health professionals and other public sector staff (for example, from agriculture and education); local government representation (i.e. from the governor or mayor's office); representatives from national and international NGOs, UN agencies, and CBOs; and religious leaders and other influential community members.

At village level, village health (or development) committees are increasingly being formed to support local health structures and **strengthen citizens' voice and accountability**. These committees often consist of a mixture of health facility staff and village representatives. In Afghanistan an effort was also made to ensure that both women, and in some cases, children, also had a voice in such committees[26]. In some post-conflict states, care must also be taken to avoid the membership of individuals with clear links to the military and/or other parties to the conflict, as they may hijack the agenda for their own political purposes. In the rural areas of the majority of fragile states, public health staff as well as committee members often lack skills and knowledge to support planning and implementation processes for devolution or deconcentration, making capacity building at sub-national levels essential for such decentralisation processes to succeed. Additionally, although the aim of strengthening citizens' voice and accountability mechanisms is for the provinces/districts to determine their own priorities, guidance from the central level usually plays a key role in ensuring that the

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[26] Annemarie ter Veen, editor. *Health Systems Strengthening in Fragile Contexts: A Report on Good Practices and New Approaches.* (Health and Fragile States Network, 2009).

plans that are created as a result of these decentralised planning mechanisms are in line with the national health strategies.

It must also be noted that communities have a formal mechanism for voicing their demands, receiving information and otherwise participating in governance through their local members of parliament. The roles parliamentarians can play in the health sector are generally not recognised in fragile states. Especially in post-conflict countries, parliamentarians are often tasked with conflict resolution and peace building. Their potential contribution to HSS frequently remains an untapped resource, and systematically involving parliamentarians in health sector coordination bodies could result in greater community ownership and support of HSS.

2.1.2   Core recommendations for supporting leadership and governance

For leadership and governance processes to succeed, a number of general principles can be applied by all stakeholders in health systems strengthening processes. These are outlined in Box 1.

BOX 1 – CORE RECOMMENDATIONS FOR SUPPORTING LEADERSHIP AND GOVERNANCE

1. Advocate for and actively participate in contextually-relevant multi-stakeholder co-ordination bodies at both national and sub-national levels.
2. Assess and map the main difficulties affecting local health service delivery, using an appropriate framework such as the six WHO building blocks.
3. Draw up a common plan to address key HSS shortcomings, setting sensible goals and targets, and clearly identifying key partners to support each of the processes.
4. Address the building of leadership and governance skills at an early stage through mentoring, partnerships and/or formal training at both national and sub-national levels.
5. Do not limit the building of leadership and governance capacity to the national level, but make a consistent effort to address it at all levels, from central government to the village level.

These activities are relevant to all health sector stakeholders in all fragile contexts. Implementation should start as early as possible, with a long-term view.

Even in cases where attention has been given to governance and state building, most donors tend to have a linear approach to state-society relations. Donors only infrequently connect programmes for strengthening institutions such as the media and reform movements from civil society with their support for reforms within government agencies. More needs to be understood about what generates greater action and interaction amongst different social movements and actors within state systems.

2.2   Health information systems

Regardless of their contextual differences, all fragile states will require support in the establishment and/or strengthening of health information and surveillance systems, the development of instruments and standardised tools for data collection and analysis, and regular collation and dissemination of national and international health statistics. This is

because even those states experiencing conflict or having weak governance are expected to improve their population's health outcomes and work towards achieving the MDGs; this progress needs to be measured. Furthermore, donor funding for any health sector, whether implemented by governments or humanitarian agencies, is conditional on that sector demonstrating progress and impact. Meanwhile, planning, whether related to determining health priorities or implementing health programs, requires a body of data to facilitate evidence-based decision making. The generation and strategic use of information, intelligence and research on health and health systems is therefore an integral part of the leadership and governance function of health systems in any fragile state. A well-functioning health management information system (HMIS) is of the essence, one which ensures the production, analysis, dissemination and use of reliable and timely information on health determinants (such as the prevalence of risk factors in a population or the availability of services to address specific health problems), health system performance and health status.

Monitoring and reporting of progress and impact requires facility and population based information and surveillance systems. In particular, accurate and robust national-level data depends on regular and effective sub-national (community, district and regional) level data collection and analysis, but these systems tend to be weak or non-existent in fragile states. Instead, health information in these states relies heavily on ad hoc local surveys conducted by NGOs, or on national surveys. Reliable population figures for the calculation of coverage and morbidity/mortality rates are frequently unavailable in fragile states, as census data tends to be incomplete or severely outdated and insecurity can result in significant (cross-border and internal) population movements. But HMIS plays a vital role in fragile states. Where systems are transparent and have outside verification, they serve as an objective way to minimise corruption in hiring, supply logistics, and patient reports. Although challenging, a good HMIS is achievable in fragile states, although it will almost always require a considerable amount of technical support, capacity building, and time to succeed.

The following section provides a practical approach to improving data gathering and analysis for HSS, but it is worth noting that separate sources of data on all the other 5 health systems building blocks need to be in place for a functional and complete HMIS. This is quite ambitious, in that very few countries in the world have effective and comprehensive data collection and analysis systems in place, but with the need to monitor progress towards the attainment of the MDGs, systems in fragile states are gradually improving.

2.2.1   Addressing health information needs along the relief to development continuum

HMIS, to the extent that they are functional in fragile states, are often limited in scope, and seldom include data from NGO or private sectors. A number of tools and guidelines are available which describe the collection and estimation of health information and indicators in the context of fragile states. These have been developed by the WHO, and are mentioned in the relevant sections of this report. Tools and guidelines specifically geared towards the strengthening of national health information systems have been developed by a consortium of partners and are made available by the Health Metrics Network.[27]

Figure 3 provides an overview of tools and methods that can be used to support monitoring and evaluation of health systems along the humanitarian aid to sustainable development

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[27] http://www.who.int/healthmetrics/en/

continuum. In a humanitarian context, the two standards that are used to guide the process of collecting and using data to assess impact and promote accountability are the **SPHERE standards**[28] and the **HAP Humanitarian Accountability and Quality Management Standard**[29] (purple box in Fig 3). SPHERE outlines the minimum standards for disaster response, focusing on simple data collection tools geared towards the most vulnerable groups using simple clinical indicators. By contrast, HAP is a quality and accountability initiative geared towards the certification of NGOs. It assesses the accountability and quality commitments made by an aid agency and as specified in their accountability framework, the processes used by the aid agency to achieve the commitments made and the quality of services provided, as defined by disaster survivors, affected communities, partners, aid practitioners and other specified stakeholders.

FIGURE 3 – DATA COLLECTION AND ANALYSIS
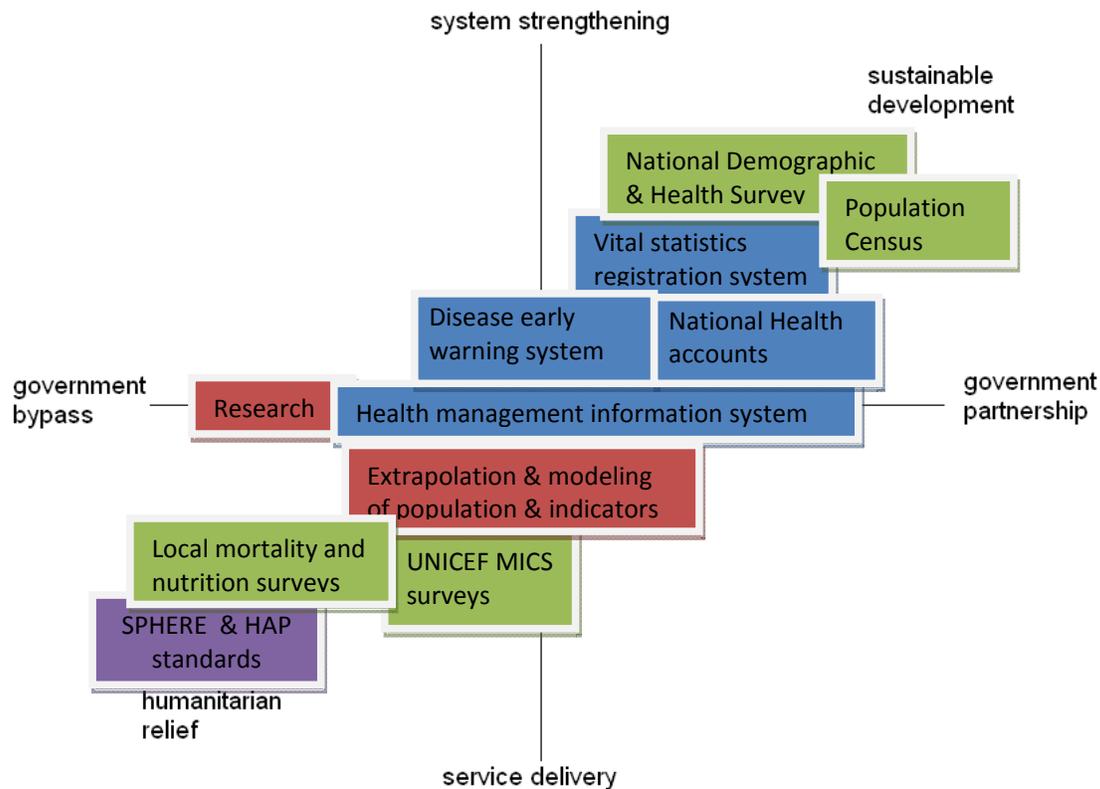
Monitoring and reporting on progress and impact ideally requires facility and population-based information and surveillance systems (blue boxes in Figure 3), but these tend to be weak or non-existent in fragile states. Instead, health information in these states relies heavily on **local mortality and nutrition surveys** conducted by NGOs, or on national surveys such as **Demographic and Health Surveys** or the **Multiple Indicator Cluster Surveys** conducted by UNICEF (green boxes). Surveys pose significant methodological and logistical challenges. They are expensive to conduct, and require considerable technical expertise in the collection and analysis of data, while results can be contentious. Nevertheless, where they exist, they are often the source of "best data" in fragile states. Where they are not available, **research studies and modeling exercises** (red boxes) can be a source of information on

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[28] http://www.sphereproject.org/
[29] http://www.hapinternational.org/standards.aspx

health indicators, although most research studies are limited in scope, and results are seldom generalisable to the entire population of a fragile state. The results of modeling exercises, a favoured method of the UN to calculate, for example, national health and fertility indicators in the absence of survey data, must be interpreted with caution. This is because some of the baseline data that they use for their calculations can be severely outdated or can be subject to extreme fluctuations in the case of large population movements. An example is the official population figure for Afghanistan, which until today has been extrapolated from an incomplete 1978 census.

Health information systems (HIS) involve more than the routine collection of data on numbers of patients seen in health facilities each month and calculating coverage using population figures. Developing an HIS also requires, among other things, a mapping exercise of all existing public health facilities, to assess functionality and staffing levels. Additionally, standardised tools and procedures for data collection and reporting are required. These include data on human resources, finances, and monitoring and evaluation results from tools such as (national) monitoring checklists, exit surveys, Balanced ScoreCards[30], local household surveys using Lot Quality Assurance Sampling (LQAS)[31], and Quality Assurance mechanisms[32]. An HIS can furthermore be expanded with data from a **Disease early warning system** (DEWS) using sentinel sites for the collection of local data on trends and changes in outbreaks of infectious diseases. The data produced by these systems has limitations. Even if data from all existing public sector services is being included, in many fragile contexts the most vulnerable populations do not necessarily seek facility-based care, and as a result their health needs may not be accounted for if HIS data is used for planning purposes.

As a fragile context progresses towards development, it is often found that inadequate health information systems and fragmented sources of funding turn the costing of national health services into an "educated guess". **National Health Accounts** (NHAs), which are part of a national health management information system, could provide more reliable information to assist in planning, but complete information on all sources of funding is seldom available. Sector-Wide Approaches and Multi-Donor Trust Funds, where funds are pooled into a single basket, could facilitate the development of NHAs as well as contributing to greater efficiency within the health sector. A toolkit for developing NHAs is available on the WHO website.[33]

As mentioned earlier, population figures for the calculation of coverage and morbidity/ mortality rates are frequently unreliable in fragile states, as census data tends to be incomplete or severely outdated and insecurity can result in significant (cross-border and internal) population movements. The most reliable way to measure actual population figures is to conduct a **population census**. Although not really a health intervention, the information is essential for planning of services and calculation of coverage indicators. Although a huge and costly undertaking, planning processes will benefit if a census is conducted in the early recovery period. However, if done too early post-conflict, figures may not include returning refugees and therefore underestimate population figures in the longer run.

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[30] P. M. Hansen et al., "Measuring and managing progress in the establishment of basic health services: the Afghanistan health sector balanced scorecard," *Int J Health Plann Manage* 23, no. 2 (2008).
[31] O. Ameli, P. Ickx, and S. Huger, "Rural Expansion of Afghanistan's Community-based Healthcare Program: Measuring Program Outcomes through Household Surveys," (Boston: Management Sciences for Health, 2004).
[32] http://www.hciproject.org/node/871
[33] http://www.who.int/health_financing/en/

Birth and death registration systems, which are a way of collecting data for the calculation of birth and mortality indicators, are generally absent in the majority of fragile states. **Vital statistics registration systems** (also called civil registration systems) are a challenge to set up, especially given the general lack of baseline data that only a population registration exercise could provide. Where they do exist, strenthening of these systems is an essential undertaking as part of HIS strengthening. In some developing countries, collection of vital statistics on births and deaths has been done through demographic surveillance sites, but over time this method also has its limitations. After a period of 5-10 years, the sentinel sites will no longer be representative of the general population due to the simple fact that data is being collected from that site. It is well-documented that by simply answering questions, people will start putting value on the issues addressed by these questions, and as a result will change associated habits and behaviour. Over the longer term, communities where births and deaths are systematically registered will become more aware of fertility and mortality rates, address where they feel there are shortcomings, and as a result they will no longer be representative of the rest of the country. Hospital statistics are another method of collecting data on births and deaths, but especially where public systems are weak, and home births and deaths are common, such an approach will result in a significant under-reporting of vital events. Collecting this information is not a waste of time, however, as data can be used for cross-validation purposes for trends when no significant changes occur in a health system.

Documents such as the Poverty Reduction Strategy Papers (PRSPs), national strategic plans, and national health strategies include indicators which require regular reporting. As surveillance systems are weak, changes in health indicators in 75 countries, including a number of fragile states, are measured every 5-10 years through a **National Demographic and Health Survey**. This yields systematically collected data that can be compared from survey to survey and between countries, and which allows for the monitoring of progress. In some post-conflict countries like Afghanistan, donor pressure has resulted in the conducting of regular national household and facility-based surveys as part of independent third-party evaluation of health services provision. These are costly exercises and the Balanced Score Card methodology in use there is so complex that an NGO or the MoH would be unable to implement it without extensive technical support. It would be worthwhile to explore the development and testing of a simpler methodology for measuring progress in the health sector.

2.2.2 Core recommendations for addressing health information systems

The UN Global Strategy for Women and Children's Health, as well as the Health Metrics Network, have identified a number of important activities for the support of national HIS, some of which have been described here. These activities are summarised in Box 2, below.

BOX 2 – CORE RECOMMENDATIONS FOR SUPPORTING HEALTH INFORMATION SYSTEMS

1. Establish a common set of essential indicators and data collection mechanisms that reflect national health priorities and capacity for data collection. Support the system to present disaggregated data (i.e. by gender, age, geographical location).
2. Advocate for the measurement of baseline indicators through (national) surveys.
3. Advocate for/update uniform, centralised reporting mechanisms, coupled with decentralised technical capacity at sub-national levels, for all health information data that include the following:
   a. A birth and death registration system;
   b. Coverage indicators;
   c. Facility-based data on access to, and coverage of, key interventions at the regional, district and community levels, including data on human resources for health and availability of essential medical supplies;
   d. Financial flows and expenditure for the entire health system.
4. Advocate for the creation of inclusive systems that involve communities and health workers, and stimulate the use of locally collected data for decision-making and advocacy.

These activities are relevant in all fragile contexts and should start as early as possible.

Monitoring and evaluation should not be activities that are exclusive to national level decision-makers. Ideally, these systems also involve communities and health workers. The latter could collect data at the local level (e.g. through their routine reporting, as well as by undertaking quality of care assessments) and provide information on whether services and resources are reaching underserved areas and populations. At present this data, even when collected, is often unutilised. Therefore, it is essential to strengthen community and local health worker capacity to collect, but also to interpret and utilise data for health (services) improvement at the local level.

FIGURE 4 – Monitoring & evaluation of health systems strengthening[34]
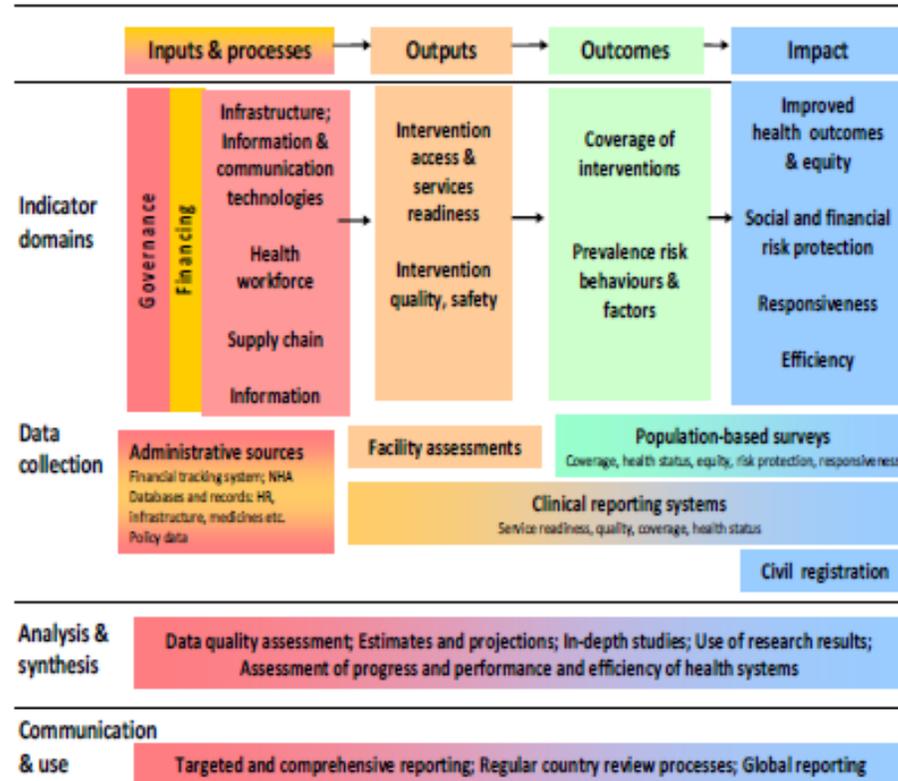
A good summary of M&E for HSS which also applies to fragile states is the operational framework on monitoring and evaluation of health systems strengthening, which was published by WHO in 2010[35]. This framework (Figure 4) indicates how health inputs are reflected in outputs, outcomes and impact for the six HSS building blocks. System inputs, processes and outputs reflect health systems capacity, whereas outcomes and impact reflect health systems performance. An effective M&E system should be able to measure changes in health system inputs such as human and financial resources and measures of output such as levels and distribution of health service access and "readiness". In turn, results such as coverage of key interventions and improved health levels and equity can then also be captured by the system.

2.3   Service delivery

Health care services should deliver effective, safe, good quality personal and population-based health care to individuals in need, when and where needed, with a minimum waste of resources. Service delivery generally consists of the interplay between vertical (i.e. disease or discipline-specific) and horizontal (integrated) approaches, with the balance between these components varying from context to context[36]. In fragile states, services are supported and implemented by a variety of actors including the government, NGOs, the private sector, and

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[34] WHO (2010). Monitoring and evaluation of health systems strengthening: an operational framework, p. 1, http://www.who.int/healthinfo/HSS_MandE_framework_Oct_2010.pdf

[35] Ibid

[36] R Atun, S Bennett, and A Duran, "When do vertical (stand-alone) programmes have a place in health systems? WHO Policy Brief," in *WHO European Ministerial Conference on Health Systems* (Tallinn, Estonia: Regional Office for Europe and European Observatory on Health Systems and Policies, 2008).

in an increasing number of cases, the communities themselves. Although there seems to be a general preference for horizontal approaches to service delivery, in humanitarian contexts many services are often supported through vertical approaches, for example by implementing programmes exclusively focusing on immunisation or the control of infectious diseases such as HIV&AIDS, malaria and tuberculosis. A number of specialist agencies, programmes and donors exist that support these vertical approaches, but weak government structures often fail to effectively merge these agencies and programmes into an integrated approach to service delivery. This can result in significant imbalances in services provision, as "vertically earmarked" funds and technical support, for example through the Global Alliance for Vaccines and Immunisation (GAVI) or the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), can be far more significant than those available to the general health system. As a result, a population may find that a given health outreach post might have bednets available but health workers might not have the training or tools necessary to provide timely and targeted counseling on birth spacing to parents.

Where service provision is characterised by inadequate and inequitable resources, low capacity and poor governance, as is often the case in fragile states, it is perhaps best to pursue modest ambitions for service delivery in the early phases of HSS. Reorganising health service delivery through a process of standardisation, for example through an essential health package, may be the best course of action to address structural constraints[37]. Cases such as Afghanistan demonstrate that initial progress in service delivery can attract additional resources, such as funds and a framework for the training of essential health staff, linked to their Basic Package of Health Services (BPHS)[38]. Henceforth capacity emerges and is strengthened as a result of the initial work accomplished, and further gradual steps can be taken that contribute to HSS.

In essence, service delivery is the outcome of a health system. The other five building blocks all serve to support its implementation and monitor its effectiveness, which illustrates once more the inter-relatedness of all elements of a health system. The following sections describe approaches to service delivery that can be taken across the relief to development continuum, but as each of the other building blocks has a supporting function, successful service delivery cannot be achieved without strengthening all the other functions of the health system. This is often overlooked, as it is far easier (and far more visible) to establish a health facility, and service delivery therefore usually gets most of the donor and government attention. However, without adequately trained human resources, a regular supply of quality drugs and medical materials, sustained leadership and financing, all supported by quality record-keeping, these health facilities may end up being no more than a one-time photo opportunity.

2.3.1   Delivering health services along the relief to development continuum

In conflict and some post-conflict settings, health services are primarily provided through NGOs and the private sector. Contracting out the delivery of a basic package of health services to NGOs during the post-conflict recovery period in Cambodia and Afghanistan led to a rapid expansion of health service delivery in those countries, as well as greater provision of care to vulnerable populations, resulting in improved equity indicators. At present, such experimental models as contracting out an essential health package to achieve service

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[37] Enrico Pavignani, "Health Service Delivery in Post-Conflict States," in *High-Level Forum on the Health MDGs* (Paris, 2005).
[38] Islamic Republic of Afghanistan, "A Basic Package of Health Services for Afghanistan," (Kabul: Ministry of Public Health, 2005).

delivery are more common in post-conflict settings than in development contexts. The private-for-profit sector, which often provides the bulk of health services in fragile states, has also been considered for inclusion in service delivery models, but especially in these contexts, their quality and regulation is poor.

Health services delivery in fragile contexts should focus on the support of multi-sectoral, community-based approaches to healthcare. Supporting sanitation and hygiene programs at the local level can have positive effects on the health sector, and in contexts of conflict, community-based organisations may also be more trusted by the population than state agencies perceived as illegitimate. Initiatives that are gaining popularity include community-based management and participation in health services, which attempts to promote community ownership and sustainability. Such initiatives can lead to greater service coverage while also improving health information systems. Community-based management is a key tenet of the recent essential health packages introduced in countries such as Liberia and Afghanistan. Although still in its infancy, performance- (or results-) based financing is another initiative to improve quality and performance which is gaining momentum. These reward mechanisms can be applied at the level of service implementers such as NGOs, as well as at health facility or individual levels and are described in more detail in the following section. Monitoring and supervision is key to the success of service delivery, both to support the continued motivation of staff and community members, as well as to prevent corruption and graft.
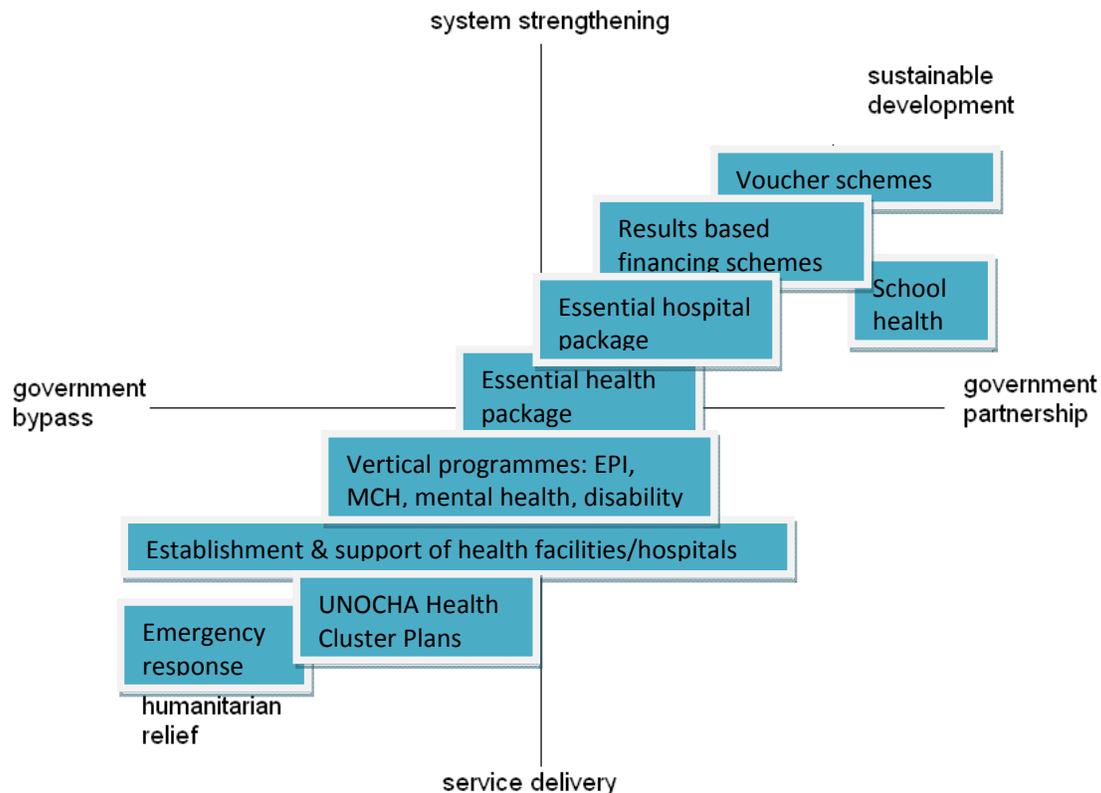
FIGURE 5 – SERVICE DELIVERY

Figure 5 outlines activities and programmes that can be implemented along the humanitarian relief to development continuum. These activities will be highlighted in the following sections, for which we have exceptionally taken Brinkerhoff's three stages (1. responding to

immediate health needs, 2. restoring essential health services, and 3. rehabilitating the health system)[39] as a rough classification of activities, with the addition of a discussion on improving coverage and quality. Service delivery itself is a huge subject, and cannot be covered in the scope of this document, therefore we have chosen to focus on core principles and approaches.

2.3.1.1 Responding to immediate health needs

At the humanitarian end of the continuum, emergency and epidemic response is generally required in the event of large influxes of IDPs, natural disasters, outbreaks of epidemic diseases and high numbers of casualties due to conflict. In a number of contexts, such as in the case of the Haitian earthquake, events can be so catastrophic that the health system is entirely destroyed. In other contexts, the existing health facilities can cope and may not need more than temporary human resources, material and logistical support.

Where present, the UNOCHA Health Cluster, usually coordinated by WHO and consisting primarily of local and international NGO members, will take the lead in coordinating the **emergency response**, although, as was the case in Haiti, it may take considerable time to establish a functional body. In many contexts, Health Clusters tend to work independently of government, but health ministry involvement should be encouraged from the outset where possible. This is because it is the health ministry, in the long run, who should be taking the lead in emergency medical response and drafting **Health Cluster plans**, and such an opportunity for capacity building should not be neglected. The effectiveness of a health cluster is often dependent on strong and dynamic leadership, clear lines of communication, well-defined responsibilities amongst cluster actors, strong links with local as well as international level stakeholders, and the availability of financing.

2.3.1.2 Restoring essential health services

No universal models for service delivery exist, but in the (early) recovery phase, governments of post-conflict states where few or no services exist can be encouraged to develop and implement a standardised, basic package of cost-effective interventions. The services offered through this package are (theoretically) based on an assessment of priority population health needs, with service provision mechanisms generally attempting to address potential demand-for-care barriers (i.e. geographic, cultural, social, financial or gender issues) in order to ensure equitable expansion of and access to services. Packages need to be feasible in terms of available resources such as money, staff, medicines and supplies, which are often limited in fragile states.

The **establishment/support of health facilities** can range from community health posts to mobile outreach visits to tertiary referral hospitals depending on the context. In countries in conflict, distinguishing between "zones of peace" and "zones of conflict" or other regional differences will allow for tailoring support for service provision to the context. Where the government retains control, it is important to determine if certain ministries or

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[39] Derick W. Brinkerhoff, "From Humanitarian and Post-conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs," (HealthSystems20/20, 2008).

specific/regional local governments can be partners in service provision, or whether non-state provision is the only feasible approach as public services deteriorate. Wherever possible, preferably with government consent, it is important to try to support public health facilities, and take over management/salaries where the government is unable to do so in order to prevent health workers from leaving, to ensure continuity of services, and to prevent the establishment of a parallel system. This applies also to existing local health volunteers who rely on the public health system for supplies, supervision and training.

At this stage, organisations can also identify essential **vertical health initiatives** that are being neglected, such as mental health and disability services. Agencies can advocate for the establishment of such specialist services or implement those services themselves when they have the capacity. Essential specialist services can be set up in a way that facilitates integration of services into government structures over a specific number of years, as was done for mental health services in Burundi[40].

2.3.1.3 Rehabilitating the health system

Massive destruction brought about by war may offer space for adopting a more rational approach to health services provision, by downsizing tertiary hospitals, which is usually out of the question in peacetime, and significantly expanding first referral and PHC facilities. International support may allow investment to be directed to underserved areas. Working with the state through multi-stakeholder coordination mechanisms, this can be the time to consider developing and costing a **basic or essential package of health services** that addresses the country's critical health issues. These packages have been developed for countries such as Somalia[41], Afghanistan[42], and Liberia[43], and focus primarily on maternal and newborn health and children under 5. They outline essential services to be provided by all primary care cadres in the health system, from community volunteers to district hospitals, and spell out the required human and material resources per type of health facility. These service packages can be rolled out eventually throughout the country and focus on providing known, cost-effective interventions. At a later stage, once the essential health package has been rolled out and referral needs to be strengthened, an **essential package of hospital services** (EPHS)[44] could be used as an approach to strengthen referral and management of tertiary services, as well as provide a baseline for costing of hospital services. Such health packages should not be treated as static documents – reviews and updates are essential in order to adapt to often rapidly-changing contexts.

2.3.1.4 Improving coverage and quality

Once a more stable level of development has been reached, and the existing health system can generally succeed in providing to the majority of the population the services outlined in

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[40] Annemarie ter Veen, editor. *Health Systems Strengthening in Fragile Contexts: A Report on Good Practices and New Approaches.* (Health and Fragile States Network, 2009).
[41] ibid
[42] Islamic Republic of Afghanistan, "A Basic Package of Health Services for Afghanistan," (Kabul: Ministry of Public Health, 2005).
[43] Government of Liberia, "Basic Package of Health and Social Welfare Services for Liberia". (Monrovia, Ministry of Health and Social Welfare, 2008).
[44] Islamic Republic of Afghanistan, "The Essential Package of Hospital Services for Afghanistan," (Kabul: Ministry of Public Health, 2005).

the health packages or other service delivery strategies, measures are often undertaken to improve coverage and quality of services. Some examples of activities that can be pursued are outlined below.

The development and implementation of an integrated **school health** programme focusing on primary school children could be considered at this stage. This is a cost-effective intervention that could include simple activities such as administration of de-worming pills and vitamin A, a check-up of nutrition and vaccination status, and basic hearing and vision screening. Such activities could also be coupled with regular school-based surveillance of infectious diseases and could support the strengthening of links between community workers, health facility staff and the communities themselves. In some countries, even those in active conflict such as the DRC, specific Child Health Days are organised. In addition to improving access to simple preventive measures, such campaigns could also lead to breaks in fighting and provide a starting point for peaceful collaboration between two sides.

The implementation of **results-based financing** schemes to improve effectiveness and staff morale is gaining popularity. Such schemes can also be implemented in congruence with BPHS and EPHS but require clear indicators and close monitoring and supervision, as these initiatives are open to abuse, and could lead to the loss of validity of the entire HMIS system if activities were systematically over-reported. Additionally, although early results of such initiatives generally appear to be positive, there are indications that they lose effectiveness once they have been in place for several years, once they become "routine".

Voucher schemes have been implemented in post-conflict countries to provide poor and high-risk urban populations with access to essential services. This approach could possibly also be considered for fragile states such as Afghanistan, where the essential health package focuses on rural populations, but leaves the urban poor devoid of free health services. Voucher schemes require close monitoring and strong technical support, as they are open to abuse and corruption.

2.3.2   Core recommendations for addressing service delivery

Response to immediate health needs in a humanitarian context is often the prerogative of the UN and NSPs. However, even during emergencies, care can be taken to provide services in such a manner that they can later be integrated into the national health system. In improving contexts, planning the future health services delivery structure becomes paramount, while at later stages, services can be expanded to include more technically complex services, and cost-effective interventions focusing on less vulnerable groups.

> **BOX 3 – CORE RECOMMENDATIONS FOR DELIVERING HEALTH SERVICES**
>
> 1. Respond to immediate health needs and restore essential preventive and curative services. This is usually done by NGOs, and coordinated by the UN Health Cluster (*deteriorating contexts*).
> 2. Advocate for and/or contribute to the development and implementation of an essential health package which sees health services delivery centering around (multi-sectoral) community-based approaches (*improving contexts*).
> 3. Monitor delivery systems to ensure that health needs of vulnerable populations are being met (i.e. women and children, the elderly, mentally ill, disabled, the poor, remote populations, minority ethnic groups), integrating essential services as early as possible.
>
> *These activities are relevant to all fragile contexts, although more relevant contexts are noted.*

An attempt is generally made, at all stages, to bring the services as close to the community as possible, and essential health packages nearly all exhibit a strong focus on community-based and community-supported services provision.

2.4 Human Resources

"Health workers" includes all people engaged in actions whose primary intent is to protect and improve health. This includes health service providers and health management and support workers in the private and public sector, working along the full continuum of care from home to hospital. An appropriately trained, well performing health workforce is essential to achieving the best health outcomes possible given the available resources and circumstances. An ideal workforce has sufficient staff, and these staff are competent, fairly distributed, responsive and productive[45]. In order for the health workforce to do its job effectively, it should also be well supported and well supplied, two key issues reflected in the health systems building blocks referring to leadership/governance and the provision of medical supplies and technology.

In many fragile states, a large proportion of the health workforce has left the country or migrated to the cities, resulting in overall shortages and imbalances in the distribution of remaining workers. Lack of human resources can severely limit the extent to which health services can be rolled out in fragile states. Additionally, the deteriorating skills and capacity of accredited training institutions has often led to the development of different cadres of staff whose competence for safe practice is not easily demonstrable[46]. In the rush to scale up health services delivery during the reconstruction phase, the limitations in the health workforce are often overlooked. There is a tendency to treat the training of a new workforce as critical for addressing the urgent short-term needs, while structural support towards the development and implementation of national workforce policies and investment plans are often not prioritised

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[45] World Health Organization, "Guide to health workforce development in post-conflict environments," (Geneva: World Health Organization, 2005); J H Smith and R L Kolehmainen-Aitken, "Establishing Human Resource Systems for Health During Postconflict Reconstruction," in *MSH Occasional Papers* (Management Sciences for Health, 2006).
[46] J. M. Smith et al., "Establishment of an accreditation system for midwifery education in Afghanistan: maintaining quality during national expansion," *Public Health* 122, no. 6 (2008).

by governments or donors. Strengthening and supporting the health workforce can be done through a variety of mechanisms, which are described in the following section.

2.4.1 Supporting the health workforce across the relief to development continuum

Fragile states have a considerable amount of catching up to do in terms of human resources planning and training, the development of norms and standards, and the establishment of human resource databases. Smith and Kolehmainen-Aitken[47] suggest a number of key steps in health workforce reconstruction in a post-conflict setting: (1) identifying available staff; (2) developing human resource management structures, systems, and capacity; (3) clarifying human resource roles and responsibilities; (4) establishing health worker equivalencies and upgrading skills; (5) supporting civil service reconstruction; and (6) widely communicating the rationale behind human resource (HR) management decisions.

FIGURE 6 – HUMAN RESOURCES FOR HEALTH
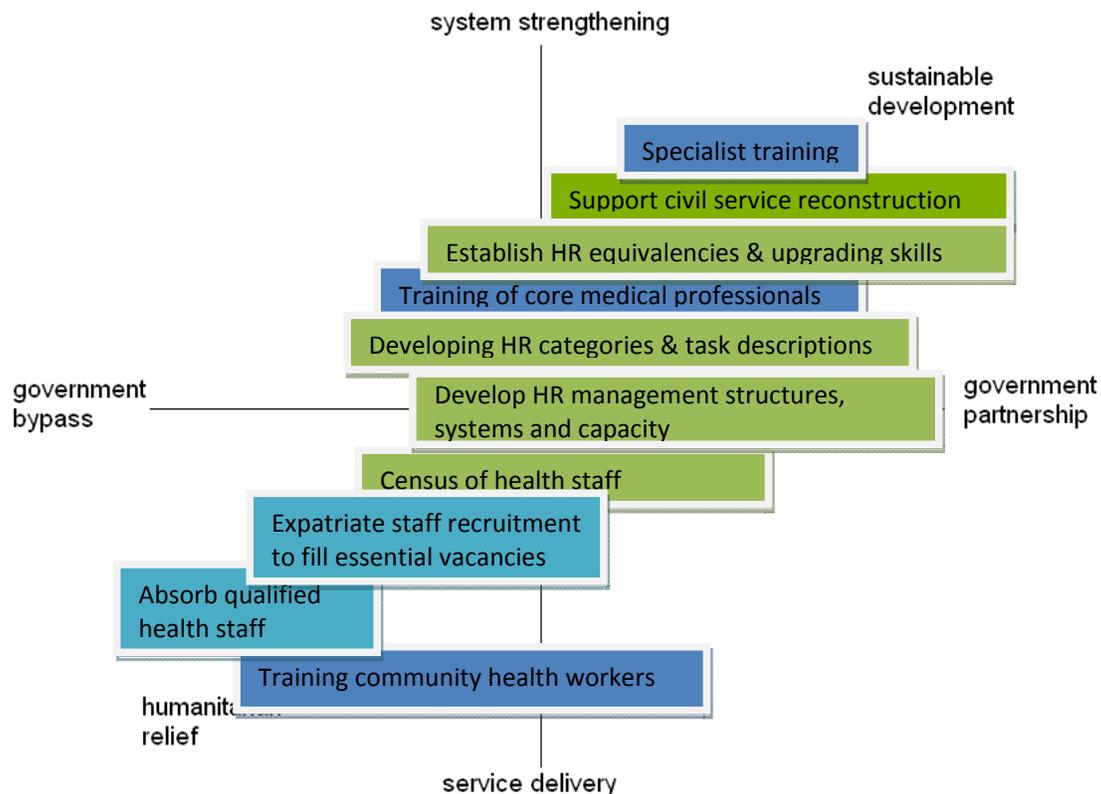
We recognise that HR is a broad topic, and that not all its components can be addressed in the scope of this paper, given that capacity building alone is the subject of numerous textbooks. We have therefore selected a number of priority activity areas, summarised as follows: (1) retention and/or supply of qualified and trained health staff (light blue boxes in Figure 6),

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[47] Smith and Kolehmainen-Aitken, "Establishing Human Resource Systems for Health During Postconflict Reconstruction."

training of essential health cadres (dark blue boxes), and the establishment of human resources frameworks to guide key processes (green boxes).

2.4.1.1 Retention and / or supply of health staff

Retention of qualified health staff is essential to prevent brain drain and/or workforce loss, which could lead to the further collapse of the health system. The blocks in light blue in Figure 6 outline some steps that could be taken to ensure that the health system remains adequately staffed in fragile contexts.

At the humanitarian end of the spectrum, the **creation of a labour market for local health workers** may result in the retention of essential staff through the provision of work, salaries, further training, and a general sense of status and respectability that employment with government, NGOs, the UN, or donors can offer. In states in conflict, the creation of such "islands of dependability" where services will continue to function, can aid in the retention of health workers, as well as allowing the population to retain some trust in the system.

One crucial issue to be considered at this stage is ensuring adequate pay. Payment of salaries and/or incentives will encourage staff to stay in the community, region or country, while bonuses can encourage staff to work or remain in remote areas. These payments, however, must not be so low that the incentive to stay is non-existent or corrupt practices are encouraged for the simple reason of survival. They must also not be so high that the local job market is disrupted. Ideally, a uniform salary scale is adopted at a very early stage in a humanitarian intervention or in a transitional context, but this requires coordination and agreement on the part of all stakeholders, and a monitoring system to ensure universal adoption of these salary scales. It is often technical support agencies, including donors and UN agencies, that offer extraordinarily high salaries in their competition for the often small numbers of qualified and gifted local staff members. This has both positive and negative impacts, negative in the sense that senior public health staff receiving salaries of approximately $50 a month can become disgruntled and de-motivated, but it can also stimulate them to improve their skills and knowledge in order to gain a $2000/month salaried job, thereby contributing to a more capable workforce over the longer term.

Where local staff are simply not present, or insufficient in number, **expatriate staff recruitment** can be considered. Recruitment of staff from neighbouring countries where numbers are adequate is an option, as well as the hiring of expatriate staff from elsewhere. In some fragile states, where security is poor, expatriate staff may be at increased risk of attack, or kidnapping. Recruitment of local staff may also be risky, as they could be seen to represent one of the parties in the conflict. Local leaders must be consulted in order to assess the level of threat to staff, and clear communication and evacuation mechanisms must be established.

2.4.1.2 Training

Limited health budgets and human resources in fragile states restrict governments' ability to achieve training targets. Where staff are available, their training is often outdated or of poor quality, and training and hiring health workers and managers at all levels is a considerable challenge. (Refresher) **training of core medical professionals** can often be a priority to update skills and create and sustain a skilled workforce. At times, however, there may be

local human resources available that are easily overlooked because they are not part of the "system", such as refugees or IDPs with adequate training, or national and international NGO staff who can contribute to capacity building of government staff without adding a significant financial or training burden to the existing health system. An example from Guinea[48], shows how refugees contributed to strengthening reproductive health services through the establishment of their own coordination body. They were able to mobilise refugee expertise by recruiting and seconding refugee nurses and midwives to local Guinean health facilities[49]. Additionally, supportive supervision can also be used by NGOs for capacity-building of both health facility and management staff in the public sector.

As indicated in Figure 6, different levels of training are often implemented at different points along the relief to development continuum. In humanitarian contexts, the rapid roll-out of essential health services nearly always requires the **training and support of community health workers** (CHWs). In some cases CHWs are paid, in other cases they are not. However, in these contexts, careful consideration must be given as to whether one is asking the poorest of the poor to provide services for free to their communities. Where this is the case, providing incentives in the form of money or tools such as sewing machines, bicycles or agricultural equipment should be considered.

During the humanitarian phase, it is seldom possible to focus on long-term training and capacity building required for specialisations in surgery, for example. Furthermore, where such candidates are sent overseas for such training, there is the risk that they may not return, or that they cannot afford to purchase, run or maintain the specialist equipment they require. Training is therefore done on the basis of "need-to-know" skills. Programmes are frequently community-based and rely on CHWs to a large extent, while highly specialised staff, who could be tasked with training and capacity building, are usually flown in from overseas. However, the presence of under-utilised health workers in safe areas in conflict zones offers room to restructure the workforce through a comprehensive retraining and upgrading programme. A process of this type took place in Mozambique towards the end of the war, spearheaded by a number of NGOs. A survey of approximately 500 RENAMO health personnel took place, coordinated by a UN agency, in consultation with the MoH and RENAMO. It found that 78% had no formal training, and with an average schooling level slightly above 5th grade, the majority of them were ineligible for direct enrolment into the public sector. A comprehensive programme to retrain the majority of them to levels equivalent to those required by the public sector was launched, which also aided in defusing tensions and demonstrating to suspicious rebels that the MoH was open to reconciliation[50].

At a systems level, the strengthening of training institutions is of the essence. These institutions can focus on training and refresher training of core health workers, such as community midwives in Afghanistan. However, they require support towards the initial development and delivery of programmes and curricula, as well as a clear accreditation framework for the profession(s) they teach. As is evident from the Mozambique RENAMO example, health staff in fragile contexts have often had poor basic schooling, through no fault

[48] Annemarie ter Veen, editor. *Health Systems Strengthening in Fragile Contexts: A Report on Good Practices and New Approaches.* (Health and Fragile States Network, 2009).

[49] Howard, N.; Kollie, S.; Souare, Y.; von Roenne, A.; Blankhart, D.; Newey, C.; Chen, M.I.; Borchert, M. *Reproductive health services for refugees by refugees in Guinea I: family planning* Confl Health, 2008; 2(1):12

[50] Pavignani, E. (2005). "Health Service Delivery in Post-Conflict States," High-Level Forum on the Health MDGs. Paris; Pavignani, E., and Colombo, A., (2001), Providing Health Services in Countries disrupted by Civil Wars: A comparative analysis of Mozambique and Angola 1975-2000.

of their own. This must be taken into account when planning training in post-conflict countries.

In a number of post-conflict contexts, innovative schemes exist where the brightest staff are selected to receive **specialist training**, ultimately with the chance to obtain scholarships for overseas studies in return for a 3-5 year commitment to work with the government upon completion of their studies. This has led to a gradual increase in capable mid-level health workers, as well as a general increase in motivation across all health sectors as clear opportunities for advancement are created. A note of caution is due however. Although the brightest staff members are generally selected to follow such postgraduate courses, course participants from fragile states are often amongst the students who require significant amounts of support from tutors and fellow students. They are more likely to fail modules and courses than their peers largely because they struggle with understanding complex concepts, due to the fact that they have often not been exposed to the basic underlying concepts during their secondary education. Tailor-made courses taught locally, targeted at the level of understanding of the participants, and with the flexibility to extend in time if it is evident that concepts are not clear, are often far more effective than sending staff from countries that have suffered from long-term fragility to short or longer courses in Western countries.

2.4.1.3 Establishment of HR frameworks

The first step in the establishment of a human resources framework involves taking a **"census" of health staff**, creating a complete **listing of the names, qualifications and place of work of all recognised health workers** employed in the public system. This includes all levels of health workers, from community health workers and other health volunteers to medical specialists. This will allow for the identification of gaps, as well as the preparation of planning projections for new staff requirements. In transitional contexts this is often achieved with the help of all existing service providers, usually the large INGOs in the country.

A second essential step is to **establish HR equivalencies**, which involves deciding on a single set of categories for all the cadres of health worker. Once the HR categories have been decided on and approved, a clear set of task descriptions must be prepared for each, along with a competency-based outline for the assessment of each HR equivalency and required criteria for upgrading. A professional code of ethics should be drawn up for health services staff, or where present it can be reviewed and updated. Efforts to maintain and strengthen this code should be undertaken at all levels of intervention. In addition, clear **HR management structures** need to be established within the health ministry, which may involve establishing a (new) human resources department and clearly outlining responsibilities and lines of communication with all relevant ministry departments as well as with NSPs.

Civil service reconstruction is essential in order to deal with issues such as poor working conditions, a lack of employment security and the dismantling of collective bargaining agreements for health staff in the public sector. The collapse of the public sector in fragile states may create the opportunity to usher in a new, modern, lean and responsive civil service, but where the state administration has survived the crisis intact, like in Mozambique, reforming it has proved challenging.

2.4.2 Core recommendations for addressing human resources for health

Without human resources, a health system cannot function. With poorly qualified human resources, a health system could run the risk of doing harm, rather than good, as medical staff may prescribe costly and unnecessary drugs, or lack the resources or training essential to keep motivation and morale high as well as to prevent the occurrence of complications or wrongful deaths. In order to strengthen essential human resources for health, a number of core strategies can be considered:

> **BOX 4 – CORE RECOMMENDATIONS FOR ADDRESSING HUMAN RESOURCES FOR HEALTH**
>
> 1. Ensure the continued employment of the maximum number of competent health staff, with specific emphasis on frontline health workers, throughout the country.
> 2. Advocate for and contribute to a census of all available health staff and their competency levels to identify gaps and plan accordingly. A census should include CHW and other volunteers. Action plans for task sharing are required to ensure that the full range of frontline workers are deployed to remote and vulnerable communities.
> 3. Advocate for and assist in the development of uniform HR task descriptions and competency levels.
> 4. Adopt and enforce a uniform national salary/incentives scale.
> 5. Invest in the continued training and capacity building of all cadres of health staff, keeping in mind that for contexts of prolonged crises, basic education will have been significantly affected and training programmes should be adapted to local capacities as well as needs.
>
> *These activities are relevant to all fragile contexts and should take place as early as possible.*

2.5 Medical products, vaccines, technology

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and the scientifically-sound and cost-effective use of these items. Even when all the other elements of a health system are in place, such as finances, trained health workers, facilities, and referral systems, their effectiveness will be extremely limited if a continuous supply of essential drugs, vaccines, and other technologies are not available. Especially in fragile states, a lack of essential supplies has led to increased costs and risks for patients and families who are forced to purchase drugs and vaccines from a generally unregulated private sector. Indicator 5 of the Paris Declaration on Aid Effectiveness[51] is concerned with the use of country procurement systems to address some of the challenges outlined here. Beyond the broader challenges relating to transparency and corruption, the use of developing country systems to procure medicines and health equipment raises issues unique to the health sector. First, quality is more important for health than it is for many other kinds of products, meaning that there are additional potential extra risks when one is dealing with local suppliers and systems. Counterfeit drugs are a serious global problem – carrying both large financial and individual health risks – and fragile states are often seen as "dumping grounds" or "potential markets"

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[51] High Level Forum on the Health MDGs, "Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability" (paper presented at the High Level Forum on Aid Effectiveness, Paris, 2005).

for these products, as government control is limited[52]. Second, international trade rules around intellectual property rights of pharmaceutical patents can pose procurement challenges. Finally, as access to medicines is an inherently political issue, governments – especially those in heavily aid-dependent fragile states – are often under pressure from donors, NGOs and activist groups to invest in particular treatment regimens or drugs which may not be available locally[53].

Building effective and accountable national procurement and drug management systems is an increasingly prominent component of the health systems action agenda, with a number of websites[54] and guidelines[55] available to assist with this process. Nevertheless, especially in the context of fragile states, this element of the health system is often the last to be addressed. In fragile states, where governance is weak, the regulation of the supply and quality of medical products is often equally weak. With the high burden of disease contributing to a high demand for medications, the lack of effective regulatory mechanisms, trained staff, and testing equipment makes fragile states inevitable "dumping grounds" for unwanted, poor quality or fake medicines. This in turn worsens a patient's chance of receiving effective treatment and could also contribute to drug resistance.

With considerable reliance on UN agencies and NGOs for health services provision, supply systems in fragile states tend to be highly fragmented, with each agency responsible for its own logistics supply cycles, training and guidelines. As the contracting-out of health services to NGOs gains popularity, this fragmentation will likely continue to exist unless health ministries actively pursue the establishment of a transparent and reliable centralised system to reduce costs and improve efficiency. Centralised procurement, supply, storage and distribution systems have often ceased to function in many fragile states, and where they do function, they often lack proper resources and are very vulnerable to leakage and corruption. Financial hardships, coupled with the collapse of these procurement and supply chains, could in some instances provide the impetus for governments in fragile states to introduce large-scale, competitive purchasing of effective, low-cost generic drugs,[56] or to absorb existing projects and initiatives that support this, but supporting this kind of activity is rarely a donor priority. It is therefore not surprising that advocacy and coordination around centralised, regulated procurement systems is a key component of the activities described in the following section.

2.5.1   Procurement and supply along the relief to development continuum

Notwithstanding the potential challenges faced in the context of fragile states, humanitarian and development agencies could start developing and supporting components of centralised procurement and supply systems in nearly all situations. It is true that most initiatives so far have been implemented in relatively stable states, but innovations are also taking place in contexts of protracted conflict, such as the Democratic Republic of the Congo, where a private central purchasing agency (FEDECAM) has been established that allows local health

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[52] Mark Thomas, "Drug Donations: corporate charity or taxpayer subsidy?," (London: War on Want, 2002).

[53] Dodd et al., "Aid Effectiveness and Health. Making Health Systems Work, Working Paper No 9."; World Health Organization, "WHO Medicines Strategy 2008-2013," (Geneva: World Health Organization, 2008).

[54] http://www.who.int/medicines/

[55] Raja Rao, Peter Mellon, and David Sarley, "Procurement Strategies for Health Commodities: An Examination of Options and Mechanisms within the Commodity Security Context," (Arlington, Va: DELIVER, for the U.S. Agency for International Development, 2006).

[56] Enrico Pavignani, "Health Service Delivery in Post-Conflict States." (2005)

services to purchase essential drugs and medical materials in bulk, which reduces costs and improves efficiency. The following Figure 7 outlines different initiatives or steps that can be taken to support the development of a functional procurement system for quality drugs and medical materials along the relief to development continuum. If agencies can collaborate with government ministries during early stages of development, or seek alignment during later stages, what might start out as a non-state led central procurement system can ultimately be taken over by a national government, as was demonstrated in Nigeria and Southern Sudan.[57]

FIGURE 7 – PROCUREMENT & SUPPLY SYSTEMS
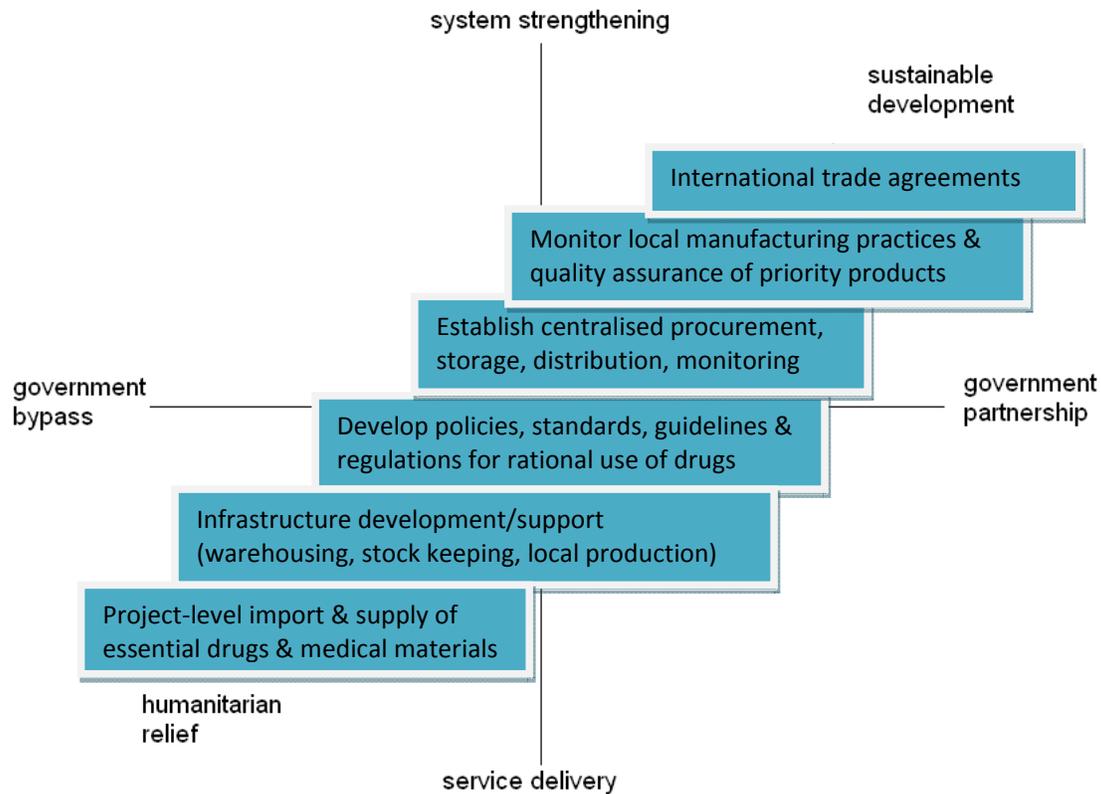
The World Health Organization has outlined a number of essential elements for an effective supply system[58]:

- National policies, standards, guidelines and regulations
- Information on prices, international trade agreements and capacity to set and negotiate prices
- Reliable manufacturing practices and quality assessment of priority products
- Procurement, supply, storage and distribution systems that minimise leakage and other waste

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[57] Annemarie ter Veen, editor. *Health Systems Strengthening in Fragile Contexts: A Report on Good Practices and New Approaches.* (Health and Fragile States Network, 2009).
[58] World Health Organization, "Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action." (WHO, 2007)

- Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to ensure adherence, reduce resistance, maximise patient safety and cover training of health workers

These elements represent the ideal and are not generally attainable in humanitarian contexts, but agencies can start early on with small-scale initiatives. This could include the establishment or rehabilitation of a central pharmacy in the capital, a mapping out of the prices, quality and efficiency of frequently used local and international supply sources, or an effort to benefit from economies of scale by either combining medical orders from a number of NSPs or by setting up a common revolving drug fund through which the government, NGOs and the private sector can obtain quality supplies.

Project-level import and supply may be the only option during the early humanitarian phase, when time is of the essence. Although most INGOs have internal regulations to ensure quality of drugs and promote the use of generics, states will often have strict regulations on drug imports, and in some cases (e.g. Indonesia), imports may not be permitted as drugs are produced locally and staff may be unfamiliar with international generic drug names. Careful negotiations with central and local authorities may be of the essence.

Infrastructure development is very context-dependent. In some settings, the infrastructure may have been completely destroyed; in other contexts it may simply be inefficient or ineffective, and in other contexts access may be an issue. In all cases, even in a humanitarian setting, efforts can be made to support the local public health system. Innovations may be required (i.e. using the budget for emergency warehouse rental to construct a new warehouse on the site of a public facility. This warehouse can be run by government staff or using existing non-medical supply lines such as Coca Cola trucks to deliver essential medicines across front lines). Establishing or supporting local production of supplies is possible in countries where drugs and medical materials are or were being locally produced. This has several benefits, in that it reduces the length of supply lines and costs of transportation (especially in the case of bulky goods such as IV fluids, and foods such as PlumpyNut which are relatively easy to produce locally), and it retains and/or builds local HR capacity.

Agencies such as MSF have developed treatment guidelines that are often used both in humanitarian and development settings. **Developing similar policies, standards, guidelines and regulations for the rational use of drugs,** which can be adapted to the local setting, is a useful exercise, as even in failed states such documents could become the pre-cursor of national guidelines if all NSPs agree to adopt them. In some cases, local treatment guidelines already exist and may even be up-to-date, but this needs to be verified. A good example of an early start in planning is the Afghan BPHS document, which describes the essential drugs that need to be available at each type of health facility. A humanitarian emergency or transitional context can present the opportunity to advocate for updating national treatment guidelines. This was done in Liberia where Artemisinin-Combination Therapy for malaria became national protocol, before any other African state took the same initiative. Production of documents is not enough: staff need training and supervision to ensure adherence. At a later stage, quality assurance protocols and monitoring can be implemented.

Establishing centralised procurement, storage, distribution and monitoring is often left for more stable contexts, although it is possible during all stages of the humanitarian aid-to-development continuum. In an early humanitarian context, centralisation is often not feasible due to the fragmented nature of aid flows, although it could (and should) be advocated for

and implemented through local coordination mechanisms such as the Health Cluster. At present, the World Bank and European Commission's contracting mechanisms involving NGOs in post-conflict countries do not promote centralised procurement, as each NGO is free to source their own drugs and medical supplies. Centralisation has considerable benefits (especially in reducing costs through economies of scale), although it is also not without its limitations. For example, if the central pharmacy runs out of a given antibiotic, an entire country may be without it. Whether centralised procurement is done through a cluster of NSPs or a single one (i.e. Pharmaciens Sans Frontières), through an independently established revolving drug fund (as was done in the DRC, Nigeria and Southern Sudan), or through the government's central pharmacy (with the associated bureaucracy and risk of corruption and misappropriation), both donors and NSPs need to be aware that technical support and strict regulation may be required for up to a decade.

Monitoring of local production and quality assurance of local drug supplies can be implemented by NSPs at an early stage in a humanitarian setting if it is felt that the local infrastructure is worth supporting. This can generally be done by sending out drug samples for quality testing to qualified laboratories, or it can be implemented at a later stage once a health system is able to take on this responsibility. Often even nascent governments wish to take on this task, for example by demanding that quality controls be done before releasing medical shipments from customs, as regulating the clearance of drugs and medical materials is a potential source of both honest income and corrupt practices. If a health system is to be supported to implement this activity independently, training and technical support is required on sampling techniques, laboratory analysis, and the development of standard operating procedures. Ensuring that the cold chain is functional and that drug storage facilities meet minimum standards are also crucial elements of this activity.

Many fragile states are signatories to **international trade agreements**, such as the World Trade Organisation's (WTO) Trade Related Aspects of Intellectual Property Rights (TRIPs) and the General Agreement of Trade in Services (GATS), which support freer trade but could also undermine a nascent health system's capacity to provide public health services[59]. As an example, the international patent system has constrained responses to many prevalent diseases in developing countries, and has restricted access to cheaper drugs. Coupled with the pressure of liberalising and privatising health services under the GATS agreements, nascent health systems in fragile states will struggle to provide even basic services. International advocacy for the liberalisation of these agreements for developing countries has met with some success, but in countries such as the DRC, neglected diseases such as trypanosomiasis continue to wreak havoc with the health of the population, while in Southern Sudan, leishmaniasis continues to be a problem for which solutions are exceedingly difficult to pursue in the current context of globalisation.

2.5.2   Core recommendations for achieving reliable supply systems

In summary, the timely supply of quality medical products, vaccines and technology in adequate amounts is a multi-faceted challenge, involving both local and international actors. Partially due to the challenges, and partially due to the specific nature of post-conflict contexts, this element of a health system is often ignored by donors and governments alike.

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[59] Radhika Balakrishnan, "Why MES with Human Rights? Integrating Macro Economic Strategies with Human Rights," (Manhattan: Mary Mount Manhattan College., 2005).

Although all the activities outlined previously contribute to building up the system, we have provided a few core recommendations in the box below.

BOX 5 – CORE RECOMMENDATIONS FOR ENSURING A RELIABLE SUPPLY SYSTEM

1. Advocate for and/or support the development and/or updating of a locally appropriate list of essential drugs, with a link to policy documents such as an essential health package.
2. Advocate for contextually appropriate centralised procurement and drug management systems.
3. Support the training of all health staff in the rational use of drugs.

These activities are relevant in all fragile contexts and should start at the earliest opportunity.

2.6   Financing health services

A good health financing system raises adequate funds for health, ensuring that people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Achieving this involves three interrelated functions: the collection of revenues (from households, companies or external agencies); the pooling of pre-paid revenues in ways that allow risks to be shared (i.e. through social or community insurance schemes); and the "purchasing" of interventions or services from, for example, NSPs by the government. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

At present, it is estimated that the 49 lowest-income countries in the world alone, including all FS, will need between US$26 billion in 2011 (US$19 per capita) and US$42 billion in 2015 (US$27 per capita) in additional aid per year to facilitate scaling up of public services to meet the MDGs[60]. This suggests that in the context of fragile states, the collection of revenues is done primarily from external agencies such as donors.

A good health financing system also promotes treatment according to need, and encourages providers to offer an effective mix of curative and preventive services, but donor dependency in fragile states seldom supports this. It is often politically advantageous for donors to raise and spend aid "vertically", in order to show a direct link between their tax monies and the results obtained. While this is a problem in all sectors, the consequences are particularly acute in health, as the sector requires flexible resources that can be used to support recurrent costs and health systems. Many donors recognise the need to provide flexible funding to support country-owned health reform plans that generally include a mixture of services. However,

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[60] United Nations Secretary-General. *Global Strategy for Women's and Children's health.* (The Partnership for Maternal, Newborn and Child Health, 2010).

concerns about public sector management and governance, particularly in fragile states, may make them reluctant to do so[61].

Thus, overall, there is a need for more innovative financing models and better ways of planning and budgeting for health service delivery in fragile states. Of particular importance is that donors and other actors address the political and bureaucratic factors that can result in a "transitional funding gap" when they are shifting from relief to development funding. This gap reflects a perceived tension between meeting humanitarian needs versus health systems strengthening, when in reality, as this paper tries to argue, the two can be complementary.

Section 3 of this document explores the role of donors in financing health systems and HSS in more detail, while the following sub-sections focus on health system financing mechanisms (and potential gaps) along the continuum from humanitarian relief to sustainable development.

2.6.1. Addressing health services financing along the relief to development continuum

Most health systems involve a mix of public and private financing and public and private provision. Prepayment mechanisms such as taxation and health insurance are generally non-existent in fragile states, resulting in limited public health services provision. Populations with high levels of poverty and a high burden of disease are therefore greatly reliant on the private sector for health services, where out-of-pocket payments contribute to a risk of financial catastrophe, often culminating in an endemic cycle of poverty and ill-health. For many people in fragile states, free access at point of care is the only way they will be able to use essential health services, and the public sector will be the only place they can turn to.

In an (early) recovery setting, health ministries face a considerable challenge in establishing and maintaining efficient and appropriate health financing mechanisms. During the transition from relief to development contexts, the mix and sequencing of aid mechanisms tends to influence whether or not funding gaps occur. The right sequencing of aid mechanisms by donors can ensure both a continuation of health service delivery and support to health system strengthening. At present, however, the use of aid mechanisms is often reactive. Better donor coordination at the country level is needed to actively prevent gaps in funding for service delivery[62], and how this can be achieved is described in more detail in Section 3. In the following paragraphs, the intent is to provide an overview of existing financing mechanisms that can be applied along the humanitarian-to-development continuum, along with a description of their relative strengths and limitations.

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[61] Andrew Cassels et al., "Effective aid, better health. A paper prepared by the task team on health as a tracer sector for the Accra Meeting 2-4 September 2008.," in *3rd High Level Forum on Aid Effectiveness* (WHO, OECD and World Bank, 2008).
[62] Ann Canavan, Petra Vergeer, and Olga Bornemisza, "Post-conflict health sectors: the myth and reality of transitional funding gaps," (Amsterdam: Royal Tropical Institute for the Health and Fragile States Network, 2008).

FIGURE 8 – FINANCING MECHANISMS[63]
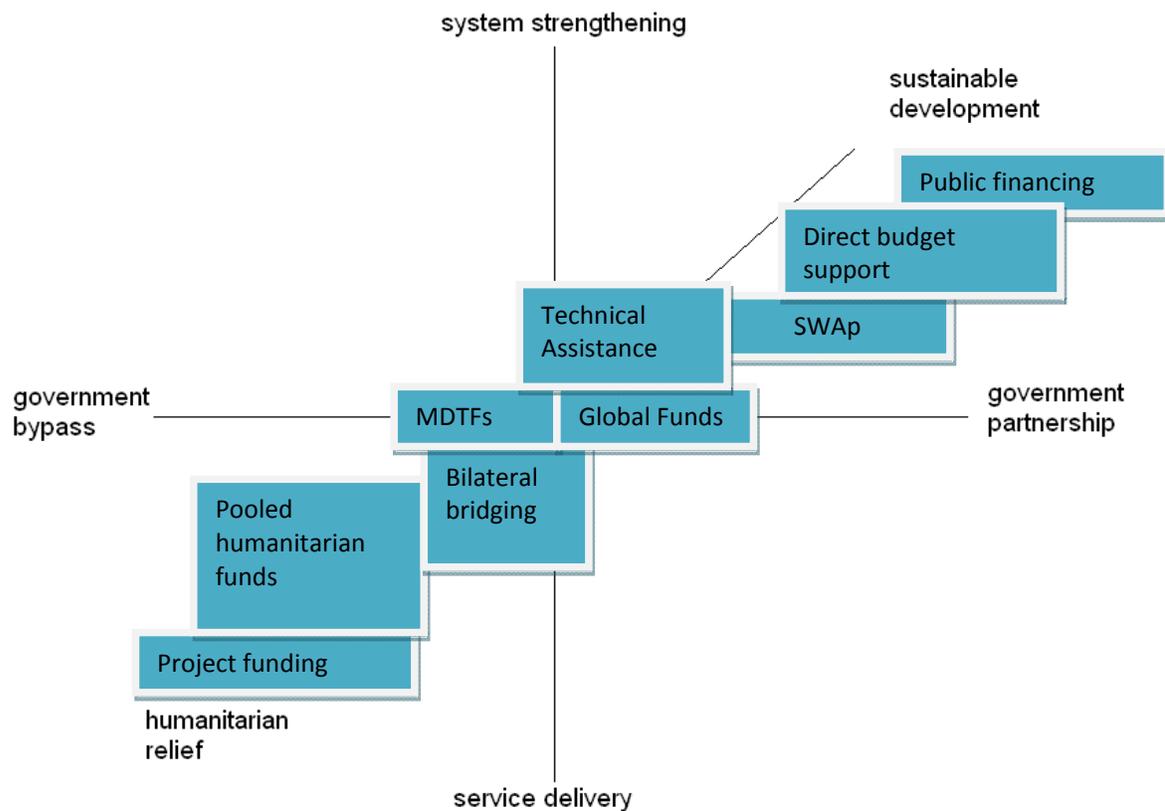
It is important to note that all health financing mechanisms can benefit from detailed costing information wherever possible. Although it is often overlooked, costing the various elements of national programmes and strategies that are to be implemented at various stages along the humanitarian-to-development continuum can prove to be very valuable. While at times results can be open to debate, such as the $4.50 per capita per year cost calculated for the implementation of the Afghan BPHS package, a nationally costed package or strategy can facilitate donor willingness to fund its implementation, as it aids budget planning. Prices that can be established even during humanitarian or early post-conflict stages include salaries (i.e. the introduction of a national salary scale), drugs, medical materials, transport, supervision and facility rehabilitation. Results can subsequently be used for costing national plans and strategies.

Project funding is still amongst the most popular funding approaches for donors in (post-) conflict settings, as it allows for rapid disbursement and response to specific needs, and is therefore an appropriate funding mechanism in the humanitarian phase, and allows agencies to address acute health needs. However, projects often do not foster collaboration and coordination amongst stakeholders, and due to very short funding cycles, sustainability and development are often not achievable. However, projects can be part of a sustainable development strategy if coordination is supported and innovation allowed. An example is the construction of a medical warehouse on the grounds of a health ministry office in West

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[63] Ibid.

Papua, Indonesia. This was possible as a result of a warehouse rental line that was considerably over-budgeted, given that the urgent nature of the project had not allowed a local assessment prior to budget submission.[64] An additional example is the establishment of health facilities in Afghanistan originally with the aim of caring for the wounded in case of active fighting. Subsequently, as fighting was not constant, it was negotiated with the donor that these facilities could be set up as primary health care facilities, and afterwards, the clinics were easily integrated into the BPHS once this policy was introduced. In order to prevent a funding gap during the transition from relief to development funding and guarantee continued coverage of basic health services, donors have established **bilateral bridging** funds, such as the Basic Services Fund provided by DFID and other donors in Southern Sudan.

A funding mechanism that is gaining in popularity in the humanitarian phase is **pooled humanitarian funding** (which includes varieties of both common humanitarian funds and development funds). In pilot countries such as Liberia, contributing donors agreed to pool resources under a common management framework, and a steering group including national authorities, donors and multilateral institutions makes decisions on allocations to sectors and projects. A variant of pooled funding used in a more stable development phase is a **Multi-donor Trust Fund (MDTF)**, where all donor resources are pooled in a single Trust Fund account. As with all pooled funds, including MDTFs, there should not be any earmarking of funds for specific programme activities or cost categories, although experience in some countries indicates that donors often still indicate "preferences". Pooled funding mechanisms have the potential to lead to a significant fiscal leveraging capacity and to opportunities for improved prioritisation and planning of interventions, coordination, and alignment with national priorities and plans. However, the performance of these mechanisms has proven highly uneven. MDTFs can be good tools as long as they are linked to a clear strategy; they require well-defined and more inclusive policies to benefit all relevant partners, as well as well-articulated procedures, and a clear link to supporting both government capacity-building and a broader development strategy in the country. Furthermore, strong coordination mechanisms are needed in order to ensure efficient administration of pooled funds, so as to address the balance of power between the UN and INGOs in the case of pooled funds more generally, and between the appointed fund administrator (e.g. World Bank) and the government specifically in the case of MDTFs. These mechanisms are also costly to implement[65]. In addition, problems associated with MDTFs are that they can be politically risky for donors and governments alike if they fail to meet expectations, and there is often a significant unmet need for capacity building for the administration of the funds[66].

Independent public-private partnerships called **Global Funds** have led to significant new health financing resources being made available worldwide: the combined aid volume for GFATM and GAVI accounted for 9% of global development assistance for health in 2007. Countries with the greatest need are issued grants in support of prevention, care, and treatment of infectious diseases, which are seen to be the most significant health priorities in developing countries. In addition to providing large-scale financing, these funds mobilise expertise and knowledge management, and cultivate awareness of health issues at political levels, but the money appears to be prioritised for treatment rather than prevention. They also are quite disease-specific, but the DRC and Southern Sudan preferred an integrated, rather

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[64] Author's personal experience.

[65] Ann Canavan, Petra Vergeer, and Olga Bornemisza, "Post-conflict health sectors: the myth and reality of transitional funding gaps," (Amsterdam: Royal Tropical Institute for the Health and Fragile States Network, 2008).

[66] Ibid.

than disease-specific approach, which was made possible through the design of an integrated planning framework.[67] Global Funds, due to the sheer volume of aid money they represent, pose major challenges to nascent governments: (i) they seem to encourage the creation of separate mechanisms for funding and delivery of health services, thus straining limited MoH capacity to manage separate funding streams; (ii) they support a complexity of applications and implementing procedures that may not always be in line with national policies and plans; and (iii) they required labour intensive monitoring processes that are not easily integrated into an HMIS. In some countries, such as Uganda, Global Funds have created challenges for efforts at health sector reform by establishing parallel systems. At present, efforts are underway to address these issues, with the managers of these funds discussing approaches to a common HSS platform and improved alignment with other key stakeholders such as WHO and the World Bank. However, these discussions are not specifically targeted to fragile states.

In many transitional settings, **technical assistance** is an important adjunct to budget support and other aid instruments. There are multiple forms of technical assistance in operation, although they are invariably insufficient for the purpose of building the core capacities of new central and peripheral systems in a country where even the most rudimentary systems are decimated. Within the MoH of a fragile context, technical assistance tends to be ad hoc and reliant upon various donors supporting advisors for health systems strengthening and vertical programs. This can lead to strengthening as well as fragmentation of the health system, depending on the number of different donor accounts being administered. Efforts towards alignment must be paramount where a great diversity of funding sources exists. Technical assistance for institutional capacity building requires a balancing of priorities between short-term objectives and longer-term needs. Nevertheless, technical assistance should not wait until a peace treaty is signed. TA to governments is required at the pre-planning phase to assist in conceptualisation of recovery strategies and choice of preferred aid modalities, with capacity building support integrated and mainstreamed rather than receiving stand-alone project support[68].

Many of the financing mechanisms described up to now support primarily self-contained projects, and are quite donor-specific. In the 1990s, donor-driven approaches began to attract criticism (i.e. for reflecting donor rather than country priorities and leading to fragmentation and duplication). It was recognised that many individual projects posed unrealistic demands on developing countries' limited economic and human resources. In response, the **Sector-Wide Approach (SWAp)** emerged. Under the SWAp, project funds contribute directly to a sector-specific umbrella and are tied to a defined sector policy under a government authority. This integrated approach is intended to result in greater efficiency and equity in the distribution of resources and to offer aid-recipient governments and sectors more flexibility in the use of funds.

A SWAp is theoretically a partnership in which government and development agencies change their relationships (towards clearer government leadership). They interact more together in the formulation of policy, and less on the details of its implementation[69]. SWAPs also have the potential to put greater emphasis on strengthened implementation capacity, and management capacity at the national and district level. They are characterised by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy

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[67] Ibid.

[68] Ibid.

[69] World Health Organization. http://www.who.int/trade/glossary/story081/en/index.html

dialogue; developing a single sector policy (that addresses private and public sector issues) and a common realistic expenditure program; common monitoring arrangements; and more coordinated procedures for funding and procurement[70].

A SWAp explicitly mandates the ministry of health with the leadership of the implementation process. This role has been problematic owing to limited leadership capacity (e.g. in Rwanda), poor relationship with the ministry of finance (e.g. in Mozambique), slow shift of ownership (e.g. in Cambodia), change of senior management (e.g. in Zambia), little ministry of health leverage to secure additional funds (e.g. in Tanzania), and low priority of cross-sectoral collaboration.

A SWAp also emphasises strengthened health sector management through the development or adaptation of management tools, combined with strengthening of implementation capacity. Under all SWAps, greater attention is given to health sector planning, financial management, and improved health information systems. SWAps also tend to emphasise strengthening district level management capability within existing decentralisation policies (e.g. in Ghana, Uganda and Tanzania).

The success of a SWAp depends mainly on the people involved and their experience, expertise and sensitivity to developing partnerships. Theoretically, a SWAp should lead to more effective partnerships between donors, governments, NGOs and the private sector, but governments may be reluctant to offer development agencies greater influence over the total pattern of expenditure in the health sector. Additionally, local and national governments may lack the necessary capacity in management, procurement, and accounting that is required for donors to hand over greater control over resources (e.g. in Papua New Guinea), therefore considerable technical assistance is generally required[71]. Attention also needs to be paid to the increased involvement of civil society actors and local leaders in the support, implementation and monitoring of SWAps, but this is often overlooked.

Under a SWAp, recipient governments and donors only fund activities in the national health sector plan. Donor funds are pooled and earmarked for high priority activities, such as essential health packages (e.g. in Uganda and Tanzania). Importantly, pooled donor funding supports government budgets, giving a much needed boost to recurrent expenditures. Furthermore, donors are responsible for synchronising their own planning, review and monitoring processes with government systems, and they give long-term projections of aid pledges. These positive developments, however, are under threat in many SWAp countries, where global health initiatives are redefining modalities of aid delivery.

Direct Budget Support happens when development agencies provide financial support to government budgets to implement a programme of policy and institutional reform that promotes growth and achieves sustainable reductions in poverty. It is a modality which brings direct donor alignment with government systems. However, donors are often hesitant to adopt it, due to concerns over weak financial systems, corruption and related weak accountability. In the context of post-conflict transitions, the proportion of direct budget support is generally relatively low. There is a distinct preference during transitions for project aid or intermediate modalities such as pooled funds or basket funds which imply shared risk

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[70] World Health Organization, "World Health Report," (2000).

[71] V Walford, "Developing sector wide approaches in the health sector," (Department for International Development Health Systems Resource Centre 1998).

among donors and enhanced control over allocation of resources. In Sierra Leone, direct budget support arguably contributed to post-conflict recovery through enhancing the legitimacy of government, sustaining peace and providing resources for basic services. It shifts the focus of aid to country systems and policy processes, thereby empowering national governments and transitional administrations to improve policies and budgets. However, while it also reduces administrative costs, this type of support is seldom used, partially due to donor requirements for planning and accountability and to (a perceived) lack of local capacity to administer these funds[72].

Public financing of health services is normally done through a variety of mechanisms, most commonly including direct user fees, microfinance instruments, community-based financing, and social security approaches. However, seeking to use these mechanisms in fragile states is difficult. User fees only cover approximately 5-10% of health facility running costs, while community-based financing mechanisms are of limited effectiveness in fragile contexts due to low levels of enrolment and cost recovery[73]. With a limited tax base and high levels of poverty and unemployment, social security is seldom an option in fragile states. Therefore, the gradual institution of a mixture of public financing mechanisms is required, to allow states to start reducing their donor-dependence – but this is a process which will take decades to implement.

2.6.2. Core recommendations for health services financing

Different types of financing mechanisms are available to governments in fragile states at various points along the humanitarian aid-to-development continuum. Each has its benefits and disadvantages, and can be implemented depending on the technical and organisational capacity of a national government and/or health ministry to support it. As has been stated previously, care must be taken so that funding gaps do not occur during the transition from relief to developmental funding approaches.

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[72] Ann Canavan, Petra Vergeer, and Olga Bornemisza, "Post-conflict health sectors: the myth and reality of transitional funding gaps," (Amsterdam: Royal Tropical Institute for the Health and Fragile States Network, 2008).

[73] Krishna D. Rao et al., "An experiment with community health funds in Afghanistan," *Health Policy Plan* 24, no. 4 (2009).

BOX 6 – CORE RECOMMENDATIONS FOR HEALTH SERVICES FINANCING

1. Collect local cost data for health services provision (i.e. salaries, drugs, materials, transport, facility rehabilitation), and contribute that information to the costing exercises for national plans and strategies.
2. Closely monitor funding streams, identifying possible transitional funding gaps and advocating for effective solutions; avoid local cost-sharing mechanisms in all stages as poverty levels are likely to be high and catastrophic health expenditures could result for individuals and families.
3. Technical assistance to governments is required in the early planning phases to assist in conceptualisation of recovery strategies and choice of preferred aid modalities, with capacity building support integrated and mainstreamed rather than receiving stand-alone project support.
4. Advocate for long-term funding mechanisms that do not aim for quick fixes, and incorporate lessons learned from other contexts, such as developing uniform reporting mechanisms across donors.

These activities are relevant in all fragile contexts and should start as early as possible.

If HSS were seen as a car driving towards its destination (i.e. population health), health care financing would be represented by the fuel stations along the way, providing the right mix of fuel to keep the vehicle running at all times. This section described ways that this "fuel" can be dispensed. The following section goes into more detail about the environments in which donors, governments, and other actors in fragile states can interact, in order to ensure that health system strengthening can actually take place.

3   Supporting an enabling environment for HSS

As discussed throughout this paper, weak or failing health delivery systems reflect political as well as technical challenges and constraints. What has occurred in the past decade are various efforts at finding effective avenues for HSS in fragile states. These efforts have spurred the work of donors and researchers towards being more consistent in identifying the lessons from country experiences and then refining approaches to working in fragile states.[74] A number of studies have provided further elaboration on country lessons in HSS,[75] and the specific challenges facing donors and INGOs[76] in regards to HSS.[77] These studies are valuable guides for both country operations and in support of efforts to align the increasingly complex donor system.

In the past decade, there have also been significant changes in the international humanitarian and development aid architectures, both in how the different components of the system are financed and in the ways that they are organised. Today, there are more actors and more diverse sources of financing than ever before. The international aid system, both the humanitarian "side" and the development "side", now consists of a complicated collection of more than 150 diverse multilateral agencies, including the UN agencies and the global and regional financial institutions. There are 33 bilateral agencies, of which 24 are members of OECD/DAC, along with at least 10 non-DAC governments (such as China and India) that are now providing significant sums of ODA.

In addition, there are a growing number of vertical global funds, such as the Global Fund on AIDS, TB and Malaria. The challenge for donors and INGOs is to ensure that there is greater cooperation and coordination of efforts in fragile states in particular. In this regard, over the past decade, mechanisms have been developed for strengthening alignment. Beyond alignment of funding, donors and INGOs are seeking to better assess current practices and design improved mechanisms for how their resources can specifically contribute to the different building blocks of HSS. The scale, breadth and mix of donors and delivery organisations means that designing and implementing coordinated and relatively simple approaches to the management of health funding and health programmes requires continual adaptation and review.

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[74] DFID, "Why We Need to Work Effectively in Fragile States" (2005); World Bank, "Engaging with Fragile States" (2006).

[75] Enrico Pavignani, "Managing External Resources in Mozambique: Building New Aid Relationships on Shifting Sands", Health Policy and Planning, 14, 1999; Ron Waldman, "Health in Fragile States: Country Case Study, Democratic Republic of the Congo", BASICS (2006); Health and Fragile States Network, Eldis site: http://www.eldis.org/go/topics/dossiers/health-and-fragile-states

[76] The particular reference to international NGOs is in regards to their multi-country programming and to their ability to engage at the global level with donors, which distinguishes them from other NSPs.

[77] Ann Canavan, Petra Vergeer, and Olga Bornemisza, "Post-conflict health sectors: the myth and reality of transitional funding gaps," (Amsterdam: Royal Tropical Institute for the Health and Fragile States Network, 2008).

Guidance on alignment and common approaches has also emerged through particular venues. The DAC has been a lead agency for addressing issues related to fragile states[78], while the Inter-Agency Standing Committee has been central in the on-going engagement of donors and INGOs on humanitarian reform. For fragile states in particular, there are now the OECD/DAC Principles of Good Engagement[79] that have been reviewed through specific country studies. The fragile states work and the humanitarian reform efforts have been increasingly incorporated by donors into both their funding modalities and their programming approaches over the past decade[80].

The reviews of how the Principles for Good Engagement[81] have been implemented can help identify the different elements for funding and action in HSS strategies. These include the focus on state-building which supports an emphasis on HSS, as well as the importance of alignment with local priorities. In addition, the principle of co-ordination measures is vital for bringing together vertical funds, multiple donors, and the various trust funds or donor projects. The Principles may also contribute to establishing the priorities for different donors within the broader scope of HSS. Lessons from other experiences can establish areas where there may be synergies and complementarities between donor programmes and where there would be value in continuing with distinct programmes. They can also contribute to a clearer understanding of how donor-financed and supported HSS fits into larger national policies and plans. Some of the initial lessons from the efforts at implementing the Principles are set out in Box 7[82] below.

BOX 7

1. Foster and as necessary exert leadership to create consensus around a common vision and to negotiate shared goals – without which achieving any sustainable impact is unlikely.

2. Root crisis prevention in sustained analysis. Circumstances in fragile settings often change fast and unpredictably and a flexible use of funding is a critical factor of successful turn-arounds.

3. Recognise that post-crisis societies present an opportunity to negotiate a new social contract – the pact between the state and citizens.

4. Recognise that statebuilding is a fundamentally political process. It is dependent on constructive state-society relations that shape expectations and build a sense of trust and legitimacy. In this sense institution-building is only one part of statebuilding.

5. Move away from the current piecemeal approach to capacity development. Jointly with national stakeholders, donors should invest in shared assessments and responses to critical capacity gaps – such efforts are almost always disjointed and reflect different administrative cultures and objectives.

6. Support domestic revenue mobilisation, identified as one of the main state-citizen accountability linkages and a vital element to improve the state's ability to fulfill its functions and derive legitimacy from it. Investment in supporting domestic revenue mobilisation in the past has paid off but remains limited in both scope and scale.

7. Recognise that effective aid is all the more important in fragile settings where priorities are many and capacities constrained, and requires a proactive approach. Aid effectiveness is constrained by domestic conditions such as the quality of national strategies and country systems, but in most cases there is room for a proactive approach that may initially involve ring fencing, shadow alignment and use of multi-donor trust funds for progressive alignment (all allowing for appropriate management of fiduciary risk), but should also improve the quality of national strategies and country systems so that alignment can increase over time.

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[78] See OECD/DAC site: http://www.oecd.org/department/0,3355,en_2649_33693550_1_1_1_1_1,00.html; and Inter-Agency Standing Committee site: http://www.humanitarianinfo.org/iasc/

[79] OECD/DAC "Principles for Good International Engagement in Fragile States." (2007)

[80] OECD/DAC, "Principles for Good International Engagement in Fragile States"; ODI, "Good Humanitarian Donorship" (2005).

[81] OECD/DAC, "Monitoring the Principles for Good International Engagement in Fragile States and Situations" (2010), http://www.oecd.org/dataoecd/18/16/44651689.pdf.

[82] Ibid, pp. 11-12.

The on-going work to find effective ways of providing health services in fragile states has also called for careful attention by donors and governments to the alignment between different aid instruments. Donors can continue to improve ways to align coordination approaches with existing mechanisms (Global Funds, Trust funds, etc.). They also can provide more flexibility for their country programmes to allow for approaches that are adapted to different contexts. Critical to this work would be the establishment of mechanisms through which predictable flows of unrestricted funding can be provided – or generated – to support the continuity of reconstruction and reform efforts in fragile states.

Currently the array of approaches and frameworks include Poverty Reduction Strategy Papers[83], Country Assistance Strategies[84], Country Assistance Frameworks, Sector Wide Approaches, and United Nations Development Assistance Frameworks. These can serve to help donors contribute to national health planning. There are also specific experiences with related mechanisms in fragile states, such as the Afghanistan Basic Package of Health Services, the Sudan Multi Donor Trust Fund and the Afghanistan Reconstruction Trust Fund.[85] Wider mechanisms include "transition matrices" such as the Liberia Results Focused Transition Framework or the Sierra Leone Transitional Results Matrix.[86] The experiences with different mechanisms can provide some specific guidance for future donor practice. They can be aligned with both the spectrum of capacity and will in fragile states, and with the various funding instruments that donors have established for different contexts (See Figure 8 in Section 2 and Box 8, below).

BOX 8: Working typology of aid frameworks and aid instruments: [87]

1. STRATEGIC PLANNING & COORDINATION	National planning and budgetary framework	Strategic planning mechanisms, typically government-led and with varying degrees of donor influence
	Poverty Reduction Strategy Paper (PRSP; iPRSP)	
	Transitional Results Matrix (TRM)	
	Joint Needs Assessment	Needs assessment
	Common Country Assessment	
	Common Humanitarian Action Plan (CHAP)	Resource mobilisation and operational coordination, at international and national level
	Consolidated Appeals Process (CAP)	
2. FINANCING & DELIVERY	Programme Aid	Financing and operational instruments, with varying degrees of alignment to the state, and harmonisation with other donors
	Technical Cooperation	
	Projects	
	Social Funds	
	Pooled Funding	
	Multi-donor Trust Funds	
	Global Funds	
	Humanitarian assistance	

[83] Nora Dudwick and Adam Nelsson, "A Stocktaking of PRSPs in Fragile States" (World Bank, 2008)
[84] World Bank, "Fragile States: Good Practices in Country Assistance Strategies" (2005)
[85] Norad, "A Review of Donor Multi-Country Trust Funds" (2007)
[86] United Nations Development Group and the World Bank, "An Operational Note on Transitional Results Matrices: Using Results-Based Frameworks in Fragile States" (2005)
[87] Nicholas Leader and Peter Colenso, "Aid Instruments in Fragile States", PRDE working Paper, DFID (2005)

Sector Wide Approaches (SWAps) are designed differently in diverse contexts, but they share a number of features. The goal is that all major donor funding for the health sector is structured to support a single framework and financial programme. The ministry of health has the lead role in the management and the process of health sector implementation. Donors will work together on shared approaches, and there is an aligned process for strengthening the government's own procedures for management of spending and accounting in the sector.

Findings from a new KIT study of SWAps in fragile states have shown that they require the sustained commitment of both government and donors, as well as a major focus on capacity building related to the core SWAp goals. The study summarised key strengths as including: the value of having both health sector and sub-sector wide strategies supported by both donors and the government ministry in question; the functioning of basic sector coordination processes based on information sharing; and the establishment and functioning of basic budgeting processes and procedures at national (and in some cases at sub-national) levels.

The study identified areas where further strengthening of SWAps and health sectors in fragile states might evolve: the sustained support of a few large donors to sector programme implementation through a multi-year plan; central government support for decentralisation (and the adaptation of vertical programme funds that can be used in support of building health systems).

The study also noted that for SWAps in fragile states, there are a number of weaknesses and threats that can undermine the links between SWAps and HSS goals. These may involve:
- disconnects between established health priorities and on-the-ground implementation of programmes;
- misaligned donor practices;
- lack of government capacity, particularly in budgeting/finance.

The study argued that in order to build an effective health SWAp in support of HSS in a fragile state, a two-stage approach might be preferable, rather than addressing all six health systems building blocks at the same time. Thus, the authors proposed that donors and the government should focus on three of the six building blocks as initial SWAp elements, those that most touch upon:

- policy formulation and coherence with strategic planning and implementation (leadership and governance);
- sector wide coordination (of service delivery); and
- the development of a basic expenditure framework with cross-cutting institutional capacity building (financing of health systems).

This initial emphasis would be followed with investment in and a deepening of all six health systems building blocks, allowing a realistic and contextually specific timeframe that will serve the interests of both the government and development partners.[88]

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[88] Ines Rothmann, Ann Canavan et al "Moving towards a sector-wide approach (SWAp) for health in fragile states: Lessons learned on the state of readiness in Timor Leste, Sierra Leone and Democratic Republic of Congo". (KIT Working Papers Series H5. Amsterdam: KIT, 2011)

HSS can also be supported through specific connections between the national health framework and the organisations tasked with delivering the health services. Following the change in government in Afghanistan in 2001, the Ministry of Public Health (MoPH), faced with a shattered health system, developed a strategy to rapidly expand the geographic scope of a Basic Package of Health Services (BPHS) to meet the health needs of its population, especially addressing rural areas and the needs of women and children.

The BPHS approach combined government management and stewardship of the health sector, while health services were contracted to NSPs[89] particularly, non-governmental organisations (NGOs), throughout most of the country. The design allowed for a coherent and balanced national monitoring and evaluation framework to measure performance in the delivery of the BPHS.

In order to monitor the progress of its health programs, the MoPH developed a Balanced Scorecard to both measure and manage the contractors who were providing different elements of the BPHS. From an initial baseline that was designed in 2004, eight of the 29 indicators were identified as the prime areas for improvement. Reviews of this experience have proposed that it is possible in fragile states to have a monitoring and indicator system that enables a health ministry to hold NSPs accountable.[90]

Whatever instruments are used, country lessons from the past decade indicate that donors, governments (where feasible) and INGOs face on-going challenges to reduce the fragmentation of resources and improve support for HSS in fragile states. Effective work on HSS in fragile contexts thus requires establishing a common, agreed framework for donors and an understanding of specific political dynamics as, within a single state, there needs to be a number of instruments and approaches for service delivery, whether public, non-state or in different combinations. Work on HSS in fragile states also requires finding ways to address mismatching goals and expectations between donors and governments. In any given country, the MoH will frequently be focused on its systems and different levels of the government bureaucracy, while donors are usually focused on specific programmes where their agency's funds are being spent and where they believe they have more leverage.

Attention to the particulars of service delivery in fragile states and factors leading to state fragility have encouraged donors to give greater attention to the overall role of government ministries, national health frameworks and capacity building processes than they had previously done. Support for the ministry of health and the need for more skilled personnel at all levels are essential areas for focus. Experiences in countries as diverse as Afghanistan, Timor, Mozambique, and Cambodia[91] point to the benefits of prioritising capacity development across the health sector. These efforts can include a national health

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[89] Non-state providers include: international NGOs, national NGOs, local CBOs, private contractors; see Richard Batley and Claire Mcloughlin (2010), 'Engagement with non-state service providers in fragile states: reconciling state-building and service delivery', *Development Policy Review*, Volume 28 Number 2; Stephen Commins, "Non-State Providers, the State and Health in Post-Conflict Fragile States", *Development in Practice,* 20, 2010.

[90] Peter M. Hansen, David H. Peters, Haseebullah Niayesh, Lakhwinder P. Singh, Vikas Dwivedi and Gilbert Burnham. "Measuring and managing progress in the establishment of basic health services: the Afghanistan Health Sector Balanced Scorecard" *International Journal Health Planning Management,* 23: 107–117 (2008)

[91] Laurie Zivetz, "Health Service Delivery in Early Recovery Fragile States", BASICS, 2006; Waldman, "Health Programming for Rebuilding States" (2007)

employment scheme that can link with the staffing and training activities of NSPs. Three criteria for such a scheme standout: (1) it reflects the larger vision for the health sector; (2) it is linked to national budgets; (3) it is realistic in terms of existing capacity and capacity building options. These approaches can allow the government to have an oversight role while sharing responsibility amongst various NSPs. National employment schemes could link contracting with human resources, wages and benefit issues, to avoid having parallel health systems. In this work, community health workers could be key bridges between the contracted agencies and the public sector.

The basis for building competent and accountable public health institutions resides in ensuring that the state can have broad and effective oversight of the health sector. At the same time, in health more than other sectors, the particular management role of the state is especially complicated, as NSPs will be connected formally to different levels of government health systems as well as local government offices. In most fragile states, there will be a continuing dynamic between the overall commitment to reduce immediate vulnerability; achieving specific health outcomes; building a more lasting and equitable health system; and building the capacity of government as well as NSPs in each of the building blocks. While each context will have specific dynamics, HSS goals, however adapted, eventually need to include greater involvement of government ministries. Government ministries in turn require both capacity and resources to establish an enabling environment for effective NSP performance, including in three key areas:

Policy environment:
- The environment for NSPs requires policy reliability and legal stability.
- The relationships between government and NSPs require trust, clear boundaries and recognition of common interests in programme goals.

Regulation
- Regulation by government needs to move beyond entry and inputs to quality;
- Governments need support in gathering information on and building capacity to regulate NSPs;
- Alternatives to, or ahead of, top-down regulation should be developed where possible, for example, through voluntary accreditation, self-regulation, and local government monitoring of services.

Contracting
- Formal contracts by government (as principal) of NSPs (as agent) require clear objectives and political support, as well as the capacity of government to monitor performance. Clear rules and complete contracts lead to productive relationships.[92]

Once a framework has been established, there are significant roles for NSPs in HSS that will differ depending on the sector, the nature of the fragile context, and the longer-term experience of NSPs in a given country. In protracted crises, NSPs provide the potential continuity of services and, depending on the context, can support capacity-building of MoH

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[92] There are some cases of effective contracting out to NSPs, and the lessons are better documented than five years ago: Sara Pavenello and James Darcy, "Improving the Provision of Basic Services for the Poor in Fragile Environments: International Literature Review Synthesis Paper" (Overseas Development Institute, 2008); Magui Moreno-Torres, "Service Delivery in a Difficult Environment: The Child-friendly Community Initiative in Sudan" (DFID, 2005); Richard Batley and Claire Mcloughlin, "State Capacity and Non-state Service Provision in Fragile and Conflict-affected States", (GSDRC Issues Paper, 2009)

and/or local government. In deteriorating contexts, NSPs may be the only available functioning organisations for basic service delivery, but even in these contexts, investment in human resources and in some elements of governmental systems may be possible. In improving contexts, NSPs need to be part of a wider health systems approach, so as to avoid setting up parallel systems. NSPs can contribute in various ways to a process of formal and informal alignment with the work of the Ministry of Health at the national level. NSPs have also been able to second staff directly to ministries to provide assistance with implementing new programmes.

There are concrete ways in which donors can connect improved health with improved governance within HSS goals. They can support mechanisms for oversight and mutual accountability in fragile states, to ensure coherence between programs, whether those of local CBOs, NSPs or governments. These oversight and accountability mechanisms may include roundtables with MoH; monthly meetings with local government; and citizen/CSO local bodies. All of these can contribute to governance and accountability in health systems. Donors can also help ensure greater transparency and accountability in their own operations, and in those of their NSP partners (international or domestic), towards service end-users. This can be through a range of instruments such as community scorecards; balanced scorecards; complaint mechanisms; community monitoring of services; and community health councils.[93] In improving contexts, it is important for international donors and NSPs to consistently coordinate and share information with appropriate government ministries, and with district and local government. In deteriorating contexts, international partners can share information and coordinate with local government agencies whenever feasible. International partners should also ensure that service provision, whether through public sector contracts or privately-funded NSP operations, does not override local capacity, skills and resources.

Donors and the MoH (where feasible) can establish a common approach (development of objectives, processes, revising analysis over time), a shared appraisal of needs, and identification of mutual priorities for technical assistance and capacity building. In order to implement the agreed-upon health goals, and to ensure citizen involvement, forums can be convened with the MoH and civil society organisations. This can help the MoH coordinate with local government bodies and CBOs, as well as national civil society networks. These fora can contribute to a common understanding of goals in relation to coordinating health services, health information systems, MoH policies, and the purposes of data collection and information for decision making. The MoH can utilise the WHO toolkit for monitoring health systems strengthening[94], and through public fora can better determine how it can be adapted to the applicable country context. This can enable the MoH and donors to establish an agreed, common monitoring framework.

In summary:

- Donors can allow for flexibility and provide incentives for adaptation and adjustment of programmes in changing circumstances.
- Donors can design mechanisms to establish longer term funding horizons, avoid overly rigid project design, and align inputs with HSS goals.

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[93] Michelle Dowst, "Working with Civil Society in Fragile States", INTRAC Policy Briefing Paper 23 (2009); Inz Zharkevich, "the Role of Civil Society in Promoting Political Accountability in Fragile States: The Case of Tajikistan" INTRAC (2010).
[94] World Health Organization, "Toolkit for monitoring health systems strengthening," (2010).

- While the acknowledged risks of working through governments – rather than parallel health services – are high, the potential benefits and influence on health systems and health outcomes require creative ways of investing in (quasi) public health systems and state institutions wherever feasible.
- Central to any approach is the long-term commitment to invest in health sector capacity through training and retraining, as well as investing in **retaining** health personnel.

4　Conclusions and recommendations

For HSS in fragile states, irrespective of whether the context is a more humanitarian aid oriented one or whether assistance is geared towards sustainable development, the *use of a common framework*, such as the six WHO building blocks used for this paper, is instrumental in helping ensure that there are no "orphan sections" within the health system. All components of a health system are inter-related and vital, and all require support.

Government, donors and other key stakeholders need to develop a health framework that is national in scope, and does not simply focus on stand-alone projects. Rather than building up from disconnected, often short-term and project-oriented approaches, it is important to think and plan long-term and programmatically from the outset, and then work out implementation methodologies. This is an area where there are frequent mismatches between donors and NSPs in terms of staff skills. There remain significant obstacles with donor organisational mandates compared to time required for HSS in fragile states. The efforts to change funding mechanisms and aid instruments will be effective when decisions on aid are not driven by donor politics and internal organisational requirements, but rather by the realities in the fragile state.

Where service provision is characterised by inadequate and inequitable resources, low capacity and poor governance, as is often the case in fragile states, it is perhaps best to pursue modest ambitions for service delivery in the early phases of HSS. Reorganising basic health service delivery through a process of standardisation, for example through an essential health package, may be the best course of action to address structural constraints, and may be more achievable (and effective) than immediately trying to address a wide variety of health systems components, even though the demand for them is there.

It is often easier, and it is claimed to be more cost-effective, to build a new programme from scratch, without utilising existing projects and capacity. Nevertheless, in HSS in FS *a concerted effort should be made to build on or integrate existing health system capacity and knowledge* wherever possible. Dismissing existing departments, systems and staff within a health system as "bad" or "poorly functioning" can result in a lack of local support, motivation and ownership. Such departments will often continue to exist due to a sense of loyalty to staff who continued to work for the health system during adverse times, and they are likely to become a burden to the system if efforts are not made to integrate them.

The sustained improvement of health systems, services and outcomes in fragile states requires *moving beyond the usual short term timeframe of humanitarian programming or the normal project cycle of donors. HSS is a process of decades, not years.* One of the biggest obstacles in assisting countries to move from fragile to stable, effective states that are capable of ensuring health and other services is the lack of long-term horizons with common end goals among all actors. This requires backwards mapping from end goals (10 years +) in order to delineate the various benchmarks along the way. It is vital to maintain a view towards the long horizon, while accepting that the path towards sustainable systems and effective governance is not smooth or without difficulties. There is a deep tendency for all actors (governments, donors, NGOs, local civil society, individual citizens) to get caught up in short-term and "project thinking" which leaves large gaps in the support for longer term goals and basic governance elements.

Fundamental to the long-term work in fragile states is the question of how to build the government's capacity to deliver health services over time, the basic premise of HSS. Or, if the government is not able or willing to deliver services in the short or even medium term, then there remains the likelihood that it will *eventually* need support for the capacity to regulate, set policies and monitor health services. In order to strengthen government capacity as much as possible, donor programmes and commitments have to be more consistent in designing their relationship with governments in the health sector. Whatever approach is taken, in order to make the process achievable and keep motivation levels high, it is imperative to divide long-term plans into short-term, feasible steps and achievable targets. Communicating such plans widely (and this includes both the short-term steps and long-term goals) will assist in building trust, both between HSS partners and implementers as well as with communities that the health system serves.

In improving contexts, there is still work required on effective approaches for the transition from a focus on service delivery to governance and civil society capacity building. More research and evaluation is required on better diagnostic tools for testing what is improving and how significant are the changes. Donors could fund NGOs and local CBOs to help identify successes, and to document and then to expand them. There is also the potential here for expanding community engagement in decision making, complemented by support for local government systems and health sector capacity.

In protracted crises, more could be done to link humanitarian mechanisms with capacity building approaches. These should not be mutually exclusive, nor should they be planned, funded and managed separately. Depending on the context, it may be possible to involve local government officials as well as the MoH. There are risks of disconnected health systems, as humanitarian goals drive the short-term activities of NSPs. Donors can develop an external health sector coordinating mechanism, as this sector is the most complex in terms of the relationships between external determinants, different types of health programs, diverse health actors, and health outcomes. Donors can also give more attention to the contracts that they develop for NSPs in protracted crises, especially as these contracts are often set out from a genuine humanitarian need basis, but lacking in linkages to any governance or longer-term framework.

Governments need to be strengthened and supported to address the challenges of working with diverse partners. A central fact of fragile states is that the majority of health services are frequently supported or delivered by various donors and NSPs. Governments therefore need a more substantial base of information on overall provider contracting and, especially, how donors and NSPs fit into and support plans for strengthening government capacity. The voice and participation of local beneficiaries should be incorporated into this process to help shape government programmes as well as the efforts of international partners.

More consistent attention needs to be focused on evaluation, learning of lessons, and sharing of information. As donors develop innovative funding mechanisms, they need to be able to track how their contracts are performing and how different health initiatives are functioning. Multi-agency information-sharing programs are needed to share lessons from fragile states with donors, governments, and NSPs.

Finally, HSS in fragile states requires a *long-term horizon* with the articulation of a clear and common donor, government and NSP strategy towards the evolution of responsibilities in

each of the building blocks. This includes evolving and adaptive, well-defined benchmarks for assumptions of responsibilities.

BOX 9 – GUIDING PRINCIPLES FOR PRACTICE IN HSS

IMPLEMENTING HSS

1. Use a common framework, such as the six WHO building blocks, to ensure that there are no "orphan sections" within the health system. All components are inter-related and vital, and all require support.
2. Be realistic. "Good enough governance" may actually be achievable, while good governance may be out of reach. Where service provision is characterised by inadequate and inequitable resources, low capacity and poor governance, as is often the case in fragile states, it is perhaps best to pursue modest ambitions for service delivery in the early phases of HSS. Reorganising health service delivery through a process of standardisation may be the best course of action to address structural constraints; for example this could be done via an essential health package, with specific considerations for the poorest and most vulnerable populations.
3. Planning should not only revolve around governments and donors. It is important to include the voice of civil society and communities. Planners should think in decades, not years, although these long-term plans should be divided into short-term, feasible steps and achievable targets to keep motivation levels high. Communicate plans widely.
4. It is easier to build a new house from scratch. However, in HSS in FS, a sincere effort to build on or incorporate existing foundations can result in higher levels of support, motivation and ownership from public sector than if an existing system and its staff are dismissed or ignored.
5. Do not be afraid of innovation. Working on HSS in FS offers a unique chance to try something new.

CREATING AN ENABLING ENVIRONMENT

6. Use a common framework and fragility assessment tools for analysing country context.
7. Adapt the donor aid architecture in ways that support the ability of both donors and NSPs to be flexible in specific fragile states and sub-national contexts.
8. If the government cannot be a partner, donors could create an external service delivery "cabinet" to provide a co-ordination mechanism, both by sector and for overall service arrangements, meanwhile encouraging continuing contextual assessment for future MoH support.
9. Donors, governments and NSPs need to pay more attention to the development of more robust and effective accountability processes, as these can contribute over time to the reduction of fragility as well as to improved health services.

Annex 1 – Putting HSS into the context of World Vision

For World Vision (WV), a review of experiences and current literature related to strengthening health systems in fragile states provides the opportunity for both an internal assessment of its own alignment in relation to fragile states and health issues, and an external analysis of the contexts for its work. Internally, the research can help to promote ways of improving the overall effectiveness of WV's field programs as well as its advocacy role in supporting the well being of children, especially in fragile states. The internal questions that WV must continually address as it works in fragile states include contextual analysis, effectiveness and accountability. Among the external issues that WV will need to consider are the specifics of country context in general; the level of government capacity; and the nature of civil society relations with the state at all levels. In addition WV needs to consider the frameworks by which donor funding strategies affect and often constrain their operations and programming approaches.

Consistently with World Vision program principles to partner with the Ministry of Health and local actors, World Vision and its donor partners can increasingly work together to address human resource constraints in fragile states with scalable activities that are linked to the six HSS building blocks. In support of HSS related goals, WV can implement community-based health initiatives which capitalise upon WV's relationships at the local level and enhance relationships across the different levels of health worker capacity and health systems.

When implemented effectively, World Vision's recovery programmes or development programmes that are based in fragile contexts can provide a credible foundation for World Vision to identify and advocate on the unique challenges in the health sector, such as the shortage of capable health workers in fragile states. From its experiences in diverse contexts working with different levels of government, World Vision should continue to identify new ideas for implementing innovative solutions to improve health outcomes at the local level. It can cooperate, where possible, with the MoH, so that its information and monitoring can be linked to government information systems. World Vision can also build upon its current health worker training programs (including Training of Trainers) to contribute to improved health services and a better functioning health system in fragile states. Such programmes should include mapping to assess current skill levels and gaps as well as investing in systems for supervising health workers and monitoring health indicators, particularly at the sub-national level.

World Vision can also assist governments and donors in addressing one of the major programmatic and information gaps in fragile states frameworks. According to the most recent UN World Urbanisation Prospects[95], around half of the world's population is living in urban areas in 2008, and the world will be increasingly urban from now on. The World Bank, in a recent piece on "The Urbanisation of Global Poverty"[96], noted a simultaneous trend towards the urbanisation of poverty, with the poor moving into towns and cities faster than the rest of the population.

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[95] United Nations Department of Economic and Social Affairs (2009). World Urbanization Prospects The 2009 Revision. http://esa.un.org/unpd/wup/Documents/WUP2009_Highlights_Final.pdf
[96] Martin Ravallion, Shaohua Chen and Prem Sangraula (2007). The Urbanization of Global Poverty. Development Research Group, World Bank

Urbanisation is characterised by the massive expansion of informal settlements and strains on existing urban work, land, services and infrastructure. For example, the number of people living in slums has doubled in India in the past 20 years and is now greater than the entire population of Britain. NGO strategies, policies and programmes need to keep up with the pace of change occurring in the urban centers.

In practice, development thinking itself retains a very rural focus, with the urban focus limited to a series of statements about the challenges of infrastructure, environment and sustainability, and urban governance. This may be because urbanisation is subsumed within the agendas of other development agendas, such as trade, economic growth, and infrastructure investments. The specific challenges of rapid urbanisation and the changing face of poverty warrant strategies that are very well articulated and forward looking.

Along with the challenges of urbanisation, there are issues in regards to how climate change and disasters relate to fragility. This is currently illustrated in Haiti and in Pakistan. Over the past decade NGOs have begun to shift from a reactive to a proactive approach to disasters. This shift led to a more integrated disaster management system, which included hazard identification and mitigation and community preparedness. More recently, NGOs have begun to give greater attention to urban disasters and urban hazardscapes. However, relatively little has been done by NGOs or donors in regards to how fragility impacts the lives of urban communities.

Finally, World Vision and other INGOs can contribute to HSS in a variety of ways, but frequently this contribution is dependent in part on public sector donors and their aid modalities. This fact underscores the importance of getting a common aid modality in place, so as to encourage shared assessments, policies and programs amongst public sector donors, international partners and national stakeholders. A well-functioning and common aid modality can help develop and support national HSS plans adapted to the country context using frameworks such as the WHO's building blocks. This aid modality can in turn promote further coordination and dialogue between donors, INGOs, government, and CBOs. Where possible, the longer time-frame required for strengthening health systems can be addressed in part through entering into longer-term agreements with donors and governments, using this aid modality. In order to contribute to greater downward accountability in fragile states, where feasible, World Vision and other NGOs should be encouraged to participate in common aid modalities to develop governance and capacity building strategies as part of HSS goals.

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