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Humanitarian
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Improving the provision of basic services for the poor in fragile environments

Health Sector International Literature Review

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The Humanitarian Policy Group at ODI is one of the world's leading teams of independent researchers and information professionals working on humanitarian issues. It is dedicated to improving humanitarian policy and practice through a combination of high-quality analysis, dialogue and debate.

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Acronyms and abbreviations

ADB:	Asian Development Bank
BPHS:	Basic Package of Health Services
CBA:	Community-Based Approaches
CFCI:	Child-Friendly Community Initiative
DRC:	Democratic Republic of Congo
INGOs:	International Non-Governmental Organisations
LICUS:	Low-Income Countries Under Stress
MDGs:	Millennium Development Goals
MoH:	Ministry of Health
NGOs:	Non-Governmental Organisations
NSPs:	Non-State Providers
OECD:	Organisation for Economic Co-operation and Development
PNG:	Papua New Guinea
PHC:	Primary Health Care
PRSPs:	Poverty Reduction Strategy Papers
P4P:	Pay for Performance
SWAps:	Sector-wide approaches
TRM:	Transitional Results Matrix
WB:	World Bank
WHO:	World Health Organisation

Section 1: Introduction

1.1 Aim and structure of the literature review

The Overseas Development Institute was commissioned to provide a rapid review of recent literature on international practice and experience in supporting pro-poor health service provision in fragile states, focusing on multilateral and bilateral donors' approaches. It was requested that particular attention be paid to literature published since the World Bank 2004 World Development Report *Making Services Work for the Poor* (World Bank 2004), a milestone in international thinking on service delivery. The overall review consists of three sectoral reports (health, water/sanitation and education) together with a Synthesis. This paper constitutes a literature review of the health sector. The purpose of the literature review was to inform the Office of Development Effectiveness' evaluation of service delivery and to contribute to a wider effort within AusAID to better understand donor engagement in fragile environments.

The report is structured as follows:

- **Section 1** sets out definitions and describes the scope, limits and method used for the review.
- **Section 2** discusses a paradigm shift in donors' engagement in fragile states: essentially from a 'projectised' and fragmented approach focused on humanitarian response to a more integrated approach which attempts to incorporate humanitarian *and* development agendas.
- **Section 3** reviews donors' approaches to supporting health service delivery in fragile states, specifically addressing instruments and frameworks; alignment and harmonisation; funding mechanisms; and approaches to reaching the poorest.
- **Section 4** concludes the review by identifying key challenges and options for donors supporting health service delivery in fragile environments.

1.2 Health service delivery and the framework of accountability

In this review the concept of health service delivery draws on the framework of accountability[1] developed by the World Bank. This refers to the relationship[2] between three broad categories of actors: *policy-makers*, who decide the level and quality of services to be offered ; *service providers*, who deliver the services; and *clients*, who are both consumers of the services and constituents of the policy-makers (World Bank 2004). As the figure below indicates, one path of accountability, the **long route**, occurs when clients can hold policy-makers accountable (for example through democratic elections), who in turn hold the providers accountable by setting service delivery standards and establishing monitoring systems and sanctions for non-compliance. Another path of accountability, the **short route**, occurs when clients can make demands directly on service providers.

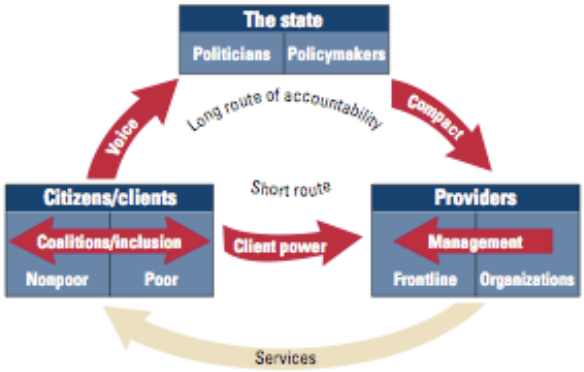
This conceptualisation of service delivery helps to highlight the three main categories of actors involved in health service delivery: public sector, private sector and civil society. In this review, private and civil society actors are referred to as Non-State Providers of Health (NSPs) and include all health providers outside the public sector, with a philanthropic or commercial motive, and whose aim is to treat illness or prevent disease (Palmer 2006). 'They include large and small commercial companies, groups of professionals such as doctors, national and international [NGOs]' and traditional healers such as herbalists and faith healers. 'The services they provide include hospitals, nursing and maternity homes clinics run by doctors, nurses, midwives' and traditional forms of medical care (*Ibid.* 3).

The nature of these relationships has a major bearing on the access of poor people to health services. In fragile environments 'health systems are trapped in a web of failed relationship of accountability' (World Bank 2004, 133): prevailing political arrangements or social patterns may prevent some – or all – citizens from being able to express their desires about which services they most need. For example, policies of exclusion, pervasive corruption or other preoccupations

[1] For a more in-depth discussion of the framework of accountability see the Synthesis report.

[2] The principal-agent model, which underpins the WDR framework, is a helpful and widely used instrument of analysis for understanding accountability relationships. If we think of citizens as the principals, and governments as the agents, then '[a]ccountability is ensured when agents have incentives to do what the principals want them to do' (Grant and Keohane 2005).

Figure 1: The framework of accountability relationship



Source: World Bank 2004, 49

(*state (un)willingness*) may deafen political leaders to citizen voices and strengthen incentives to provide services, for example only as political rewards. In other cases, a lack of administrative capacity or financial resources (*(lack of) state capacity*) may undermine the ability of policy-makers to make sure that good health services are indeed delivered (OECD/OCDE 2006, 9). Donors' support to *pro-poor health service delivery* should therefore aim at supporting 'interventions that maximise the access and participation of the poor by strengthening the relationships between policy makers, providers and service users' (Berry et al. 2004, Carlson et al. 2005).

1.3 The challenges to delivering health services to the poor in fragile states

Given the serious governance deficits that characterise fragile states, which may be further exacerbated by internal conflict and insecurity, support to pro-poor health service provision is an especially difficult process: risky, very costly and fraught with challenges. Existing health systems are usually biased towards the better-off, rather than being pro-poor, and invariably 'they have been subjected to prolonged periods of outright neglect and decay' (HLF 2004, 9). Donors are therefore faced with continuous challenges – including tensions and potential trade-offs – when supporting health service delivery in such contexts. Three of the major challenges are addressed in this review (see below), along with examples of approaches that have attempted to deal with those challenges. Given the limited scope of this review, this report can only indicate some of the options rather than attempting anything more comprehensive. But in fact a review of the literature indicates a substantial research gap: more and better evidence is needed to identify the approaches best suited for health service delivery in fragile environments, as well as the most appropriate mix of health providers, allowing that every fragile environment is necessarily different.

Challenge 1: What is the appropriate balance between addressing immediate needs and building long-term capacity?

'In most fragile states, there will be a continuing dynamic between reducing immediate vulnerability; achieving specific health outcomes; building a more lasting and equitable health system; and building … capacity' (HLF 2005(a), 3). This is a well-known challenge, and is widely discussed in the literature (Berry et al. 2004, Commins 2005, DFID 2005, Newbrander 2007, OECD/OCDE 2006, OECD 2007, Waldman 2006(a) and (b), and many others). On the one hand, donors are faced with the need to answer to the immediate health needs of the poor where health services are weak or non-existent, by delivering and scaling up health services quickly, for example with interventions aimed at tackling disease outbreaks or high mortality rates. On the other hand, there is an increasing recognition of the need to engage in long-term activities that address the underlying cause of such health crises. This requires interventions aimed at (re)building national capacity and (re)establishing public stewardship of basic service delivery. To this end, donors' efforts need to be formulated in a way that takes the issue of long-term sustainability into account, with the aim of bringing about broader institutional and policy changes, for example strengthening weak or non-existent chains of accountability between the various health services actors. Institutional change is however a complex and long-term process and it may be argued that sustainability in very weak contexts may not be a realistic goal. The key question therefore is: what mechanisms and approaches are most likely to address immediate health needs *while* building state capacity in the longer term, or at least not weakening it in the short term?

Challenge 2: What is the appropriate balance between engaging with the public sector and with NSPs?

Another challenge relates to which health service providers donors should support or partner with in these contexts. To what extent should their engagement involve partner governments,

historically seen as the key actor of public service delivery? And to what extent should donors partner with other service providers outside of the public sector? This point is especially relevant for the health sector because, in most low-income countries, health services are predominantly non-state at the point of delivery, and involve an exceptionally diverse range of NSPs (OECD/OCDE 2006, 40). The poorest strata of the population are more likely to use NSPs as their principal source of care, in part because of easier accessibility: for example private clinics may be open longer hours, or a traditional healer in a remote area may be closer than a hospital (Palmer 2006). Moreover, 'unorganized markets and unregulated pluralism of provision' are significant features of the health sector in fragile states (Moran and Batley 2004, 12). On the one hand, 'both for reasons of long term sustainability of service delivery programs, as well as for the necessity of building, however slowly, effective, transparent and accountable public institutions' (Commins 2005, 2), donors should involve national actors such as the MoH in health service management and/or delivery, rather than bypassing them. On the other hand, in fragile environments those institutions may be unwilling or may lack the capacity to engage in pro-poor service delivery, which inevitably pushes donors to seek partnerships with alternative service providers. In other words, drawing on the accountability framework, donors face a challenge between choosing interventions that use the short route of accountability (NSPs), which allows them to respond to the humanitarian imperative and quickly scale up service delivery in the short- to medium-term, and interventions that use and strengthen the longer route (public sector), which contributes to (re)building state capacity and ensuring long-term sustainable and equitable health service delivery. In some cases, when the government is weak, absent or mistrusted, NSPs may be key health providers. The crucial issue is to harness NSPs to achieve health objectives, while keeping in view the need to develop the capacity of governments over time. Indeed, 'short-route mechanisms should be complemented by longer-term approaches that can help develop the long route of accountability' (OECD/OCDE 2006, 20).

Challenge 3: What is the appropriate balance between supporting central and local government?

Another challenge for donors is to decide whether and to what extent their engagement should be with central institutions or with district, provincial or local-level institutions. This matters, not least because in fragile states particularly there is often a need to go *beyond* the national level to explore the regions where the central power has never really fully penetrated (Debiel et al. 2005). In many fragile environments, '[w]hile the national government may have the regulatory and policy role, local government can play a key role in coordination and information sharing amongst providers' (OECD/DAC 2006, 38). This point is especially relevant for this analysis: '[i]n many countries, the state administrative structure is replicated in the health sector, with central, intermediate (province or regions or states) and peripheral (districts or counties) layers. These administrative units may have been [long] established … and have in this way gained strong significance in the eyes of local constituencies' (WHO 2007, Module 8). For example, in Northern Nigeria or in rural regions of Afghanistan, social stability and welfare relies on traditional or local organisations and institutions which often enjoy higher levels of legitimacy than national ones (*Ibid.*).

We refer back to these three challenges in the following sections.

1.4 Scope and limitations of the review

This review recognises and highlights the fact that support to health service delivery is only part of donors' broader engagement in fragile states, which may also include efforts to address issues of security and stabilisation, peace-building, governance etc. It also acknowledges that the attainment of a healthy population and the reduction of risks to health necessarily entails the implementation of interventions that, in addition to the health services, address broader determinants of health, such as water and sanitation, education and housing (Alma Ata Declaration 1978; AusAID 2006, 24; HLF 2004, 7; HLF 2005(a), 4; Patrick and Brown 2007, 2). However, for the purpose of this analysis and because of time constraints, this review is limited to the literature that focuses on the delivery of essential health services within the primary health care spectrum (PHC – as defined below).

The review has three main limitations. First, by its nature, it is not prescriptive: it does not offer policy prescriptions and does not seek to judge the validity and appropriateness of the various donor approaches referred to. Second, it does not investigate donors' wider approaches to and strategies in fragile states, but considers these only in relation to the support of health systems and health service delivery. (Some of the more

general issues relating to donor engagement with fragile states are considered in the Synthesis report.) Third, this report does not review in-depth country case studies, but points to brief examples of interventions, or components of programmes, in several countries including East Timor, PNG, Afghanistan, Sudan, DRC and Haiti, by way of illustration of more general lines of analysis.

Section 2: The nature of donors' engagement in fragile states: a paradigm shift

The growing concern with fragile states in recent years, and the realisation that one of the key reasons for supporting health service delivery in these environments is that it may be an entry point for triggering broader governance reforms (World Bank 2005, Berry et al. 2004), has led donors to question the effectiveness of their modes of engagement.

The nature of donors' engagement in those environments is clearly illustrated by DFID:

> *Much aid in fragile states is delivered through short-term, uncoordinated projects which are not part of a broader development strategy. Much of this support is labelled 'humanitarian', and it has become the dominant mode of working in fragile states because it is delivered outside state structures. Humanitarian agencies are used to working in insecure environments and can often reach poor people and provide services when others cannot. But humanitarian assistance is not effective in laying the foundations for longer-term development. It can also undermine state capacity by, for example, leaching scarce skilled personnel away from the domestic public sector* (DFID 2005, 12, see also Leader and Colenso 2005, 40).

Inherent governance deficits, which may be exacerbated by violent conflict, have led donors to treat those environments as 'humanitarian emergencies', and consequently their service delivery efforts have often bypassed the state altogether and have relied on NSPs to deliver services (DFID 2005). For example, if the MoH lacks the willingness and/or capacity and 'function[s] poorly in terms of staff morale, management capability and policy formulation' (HLF 2004, 4), the temptation to avoid a partnership is both understandable and (as discussed in Section 4 below) in some cases unavoidable. There is however a growing recognition that, even in the most challenging environments, 'the possibility of eventual transfers to the state, at least of the regulatory function, needs to be built into programme design' (DFID 2005, 23). Ultimately, the responsibility for the country's health system and the management of the well-being of the population (stewardship) lies with the state (Commins 2005, 6, WHO 2000, 135)[3].

According to the World Bank:

> *Short-term, ad hoc, project-based models of engagement in fragile states have proved to be unsuited for the central task of state (re)building and past experiences have demonstrated that '[s]ustaining parallel agencies that by-pass mainstream structures – which are often essential in tackling short-term emergencies (through, for example, social funds) – can do damage over the longer term by undermining the legitimacy of governments'* (World Bank 2005, 6).

The creation of an enabling environment to support the delivery of basic services, a key objective of donors' interventions, is increasingly conceptualised as a political rather than a technical problem (AusAID 2006, DFID 2005, 14, Carlson et al. 2005, OECD/OCDE 2006, Waldman 2007). Consequently, a sound and objective political analysis of the situation on the ground is widely seen as a prerequisite for donors' engagement in fragile states[4] (AusAID 2007, Commins 2005, 8; DFID 2005, 23; OECD 2007, 1; OECD/OCDE 2006; Waldman 2006 (a), and many others). The increasingly political nature of donors' programming in fragile contexts needs to be seen as a significant departure from traditional approaches, which were built on either full acceptance of state 'legitimacy' – such as with direct budget support, or its rejection (Leader and Colenso 2005).

Engagement that narrowly focuses on the promotion of 'vertical' or special health programmes is increasingly seen as having 'side-effects' for the development of an integrated health system in the longer term. This issue is clearly identified by WHO:

[3] The discussion relating to the role of the state and public service delivery will be discussed in the Synthesis paper.

[4] DFID's 'drivers of change', for example, rest on key elements such as the 'need to understand the history of a country and its people, who holds power and how it is brokered and used, the informal "rules of the game" (such as how patronage networks operate in government and business), and the relationship between these and formal institutions' (DFID 2005, 14, see also AusAID 2007, 29).

> *Fragmentation can attain extreme degrees, such as in* ***Angola*** *in the 90s, where about thirty vertical programmes (in some case real, but often rather virtual) were expected to support a large array of health activities. Setting up a special programme … becomes the favourite way of addressing a problem. In partitioned settings, multiple programmes may be in place to address the same health issue … Special programmes tend to establish separated management systems, which consolidate and expand during protracted crises. Thus, the same facility can be supplied with drugs from several sources and report activities to different authorities. In* ***Southern Sudan****, the polio eradication programme operates a large stand-alone system that dwarfs general health services [and] it has created its own territorial boundaries* (WHO 2007, Module 8).

Recognition that a projectised, fragmented approach can reduce already fragile relationships of accountability and build parallel systems has led to the view that the promotion of vertical or disease-specific programmes in order to quickly scale up health services to respond to humanitarian imperatives should be *complemented* by a 'broad commitment to the health systems over a long time frame, incorporating humanitarian *and* development agendas' (OECD/OCDE 2006, 39 emphasis added, see also Leader and Colenso 2005, HLF 2005 (a), Newbrander 2007). For example, when the health system is seriously disrupted and vertical programmes are interrupted or abandoned, 'the results include not only the immediate human costs and waste of resources, but the lasting legacy of new drug-resistant strains of disease, followed by skepticism about aid effectiveness more generally' (Lele et al.). 'The World Bank, for example, has rapidly increased its assistance for communicable disease programs, particularly against HIV/AIDS and most recently for malaria, in response to the growing need and strong advocacy. But the Bank's and other donors' aid for overall health delivery services in countries has grown very little, leaving critical needs unmet' (*Ibid.*). There is a growing consensus therefore that, in order to achieve sustainable improvements in health in poor countries, and indeed in fragile states, donors will need to achieve a better balance between vertical and horizontal approaches (*Ibid.*).

Section 3: Donors' approaches to supporting health service provision in fragile environments

We focus here on two levels of analysis: *how* should health services be delivered, and *who* should be providing the services (HLF 2004, 13). Focusing on the 'how' allows investigation of the approaches and frameworks, instruments and funding mechanisms used by donors to guide their engagement in fragile states. Focusing on the 'who' allows discussion of the role of the various actors involved in service delivery (public or NSPs actors) and the ways in which donors can best harness their potential. A key theme that has emerged from the literature review is that in '*all* types of fragile states, a longer-term vision of a pro-poor health system is important while taking short-term measures' (HLF 2004, 11 emphasis added, Carlson et al. 2005, 7). While this is a widely agreed principle, in practice it is very difficult to operationalise: the approaches, strategies and concrete examples below illustrate some of the practical measures that donors can consider, even in the most difficult environments.

The need to scale up services to expand service delivery in fragile environments underpins several of the approaches that will be discussed below, such as contracting, P4P, BPHS and community-based initiatives. Scaling up in terms of expansion of coverage and availability of services may be done in two ways: through government structures or through NSPs (Torres 2006). As highlighted above, donors need to deal with challenges and trade-offs, and in particular need to consider the role of NSPs and the effect that they will have on state legitimacy and on long-term capacity-building. In considering ways to scale up services to support health service delivery, donors need to keep in mind the following: 'the key in building competent and accountable public health institutions resides in ensuring that the state can have broad and effective oversight of the health sector' (OECD/OCDE 2006, 40).

In the literature reviewed the issue of scaling up appears to be discussed as part of general lines of analysis in relation to donors' approaches in fragile states. Similarly, in this review, rather than engaging in an in-depth analysis of scaling up services, this topic will be referred to in the wider context of donors' approaches and strategies, discussed below.

3.1 General approaches and strategies

Preventing further deterioration

In very fragile environments, where high levels of violence and/or serious governance deficits make service delivery extremely difficult, *preventing further deterioration* of the health system, rather than attempting to improve it, may be a starting point. The advantages of this approach are twofold: 1) keeping a health system afloat during a difficult time is cheaper than rebuilding it at a later stage; and 2) maintaining trust in the health service and providing vital input to subsequent rebuilding efforts is crucial (Carlson et al. 2005; HLF 2004, HLF 2005(c),13[5]). For example, years of political upheaval and conflict and neglect of basic service delivery in the DR Congo resulted in a highly disrupted and non-government-funded health service system. During the worst years of the conflict, the European Commission policy in the DRC, which was also the policy of other main donors in agreement with the WHO, was of 'no enlargement and no regression': the aim was simply to maintain the existing structure and health staff in place, so that no further deterioration occurred (Carlson et al. 2005, 7).

Basic Package of Health Services (BPHS)

The implementation of a BPHS (also referred to as an 'essential care package' or 'minimal healthcare package') is seen as a cornerstone of the emergence of a functioning health system in fragile states emerging from conflict (Newbrander 2007). It is perceived as having the potential to integrate vertical disease-specific intervention with a more horizontal, system-wide approach. Promoting a BPHS may therefore be a useful approach for trying to address the challenge of linking quick impacts to longer-term goals in the early stage of reconstruction (Waldman 2006 (a), OECD/OCDE 2006). Usually, a BPHS 'specifies the physical characteristics of health facilities, their distribution on a population basis, their staffing patterns, and their specific public health interventions' (Waldman 2007, 3), which for example may include emergency obstetric care, family planning and immunisation. While the implementation of a BPHS presents several challenges,[6] there are several advantages,

[5] See HLF 2005(c),13 for a list of other recommendations on health best practice in post-conflict states.

[6] Specific challenges may be: what exactly should be included in the package, who is setting the agenda,

including: a) it is a pro-poor intervention as it concentrates health service delivery to benefit the poorest and the most vulnerable (e.g. women and children) (Odaga 2004); b) it promotes the development of a common (donors and partner governments) vision of priorities for the health sector and the establishment of a coherent framework for delivery of essential services; and c) it may be an effective way of scaling up services[7] as it may increase access to PHC at the community and district levels (LSHTM 2007, Newbrander 2007). In recent years, BPHS have been implemented in collaboration with health authorities in Afghanistan, DRC, East Timor, Liberia and Somalia.

In the DRC the formulation and implementation of a BPHS has provided 'policy coherence and uniformity of service delivery to an unguided and uncoordinated system' (Waldman 2006 (b)). In East Timor, the WB implemented the Health Sector Rehabilitation and Development Programme with the purpose of addressing immediate basic health needs. The BPHS was implemented as part of this programme in the immediate post-conflict stage. A study concluded that 'gains in geographical equality are likely to have occurred, through standardizing of health services and provision of the same basic package of care throughout the country, in place of different standards depending on the different levels of performance due to the specific background, experience and resources of individual NGOs' (Alonso and Brugha 2006).

Which health service actors should donors support or partner with when engaging in fragile environments? As the discussion above indicates, in cases where there is some capacity and willingness, donors should consider state providers as the entry point for service delivery as this is an effective way to build state capacity while minimising the risk of undermining existing relationships of accountability (Berry et al. 2004). However, where there are serious governance deficits and weak capacity, 'building capacity in the private sector and civil society can be a starting point' (DFID 2005, 13). Partnering with NSPs to improve health services in fragile states is often necessary and desirable, since in many fragile contexts NSPs are vital service providers (see for example the key role that churches play in the health sector in PNG). At the same time, however, donors need to keep in mind that working exclusively through NSPs will inevitably lack breadth of impact and sustainability simply because civil society organisations cannot design national policies and standards; nor can they substitute in the long term for the citizen–policy-maker relationship (World Bank 2004, 215, Commins 2005, Newbrander 2007), or scale up services to achieve universal coverage. The crucial question therefore is: what mechanisms can donors use in order to harness NSPs while at the same time building state capacity?

Contracting

One approach that is increasingly adopted is **contracting**, which is seen as a good way to engage with governments and strengthen their coordination and capacity, while allowing for alternative approaches to service delivery, which, for example, may take advantage of the private sector and use competition to scale up services and increase effectiveness and efficiency (World Bank 2006). Contracting entails leaving the management function of the health sector to the public sector, while giving responsibility for delivery of health services to the private or civil society sector. In this way, the state retains the stewardship function by setting policies and regulating provision, but delegates service delivery by purchasing services via contracts with NSPs. While there is mounting evidence that contracting with non-state providers for health service delivery is more effective and efficient than using the state health system (LSHTM 2007), and that contracting may be a good approach for scaling up health services quickly (Newbrander 2007), contracting to NSPs should be carefully considered especially in relation to the issue of state legitimacy in fragile states. Contracting may potentially end up further eroding state legitimacy in the eyes of citizens (Palmer et al. 2006, Newbrander 2007). Contracting has been implemented in Afghanistan, Cambodia and the DRC.

In Afghanistan, the government plays an umbrella role in policy, direction, regulation, standardisation and monitoring of health services, but has contracted out health service delivery to external agencies. The World Bank has assumed a leading role in providing the vision and drive for

how to cater for health problems that fall outside the package or for new vertical programmes that bring in new interventions, the problematic issue of continuous monitoring and many other issues; see for example LSHTM 2007, Odaga 2004.

[7] It is important to note that the emphasis on cost-effectiveness that characterises BPHS interventions may also discourage the provision of services to the most hard to reach populations, thus negatively impacting on issues of equity and the scaling up of services (LSHTM 2007).

the contracting system (Carlson et al. 2005). A compact of donors, in collaboration with the MoH, is funding contracts with NGOs. Contracting in this context is perceived to have practical and political advantages. NGOs were already running most facilities, and are experienced in the difficulties of delivering services in Afghanistan. NGOs are also often more flexible than government in their ability to recruit new staff and set up services rapidly. Moreover, some NGOs have the financial and logistical backing of large international organisations, and may be able to supplement contract funds with their own resources. The motivation of NGOs is also generally expected to be closer to that of public providers than that of the private sector, and contracts with NGOs are seen as taking advantage of the voluntary sector in terms of greater flexibility, innovation and morale (Palmer et al. 2006). In Afghanistan, contracting seems to have produced positive results in terms of large reductions in child mortality, and improvements in reproductive health and in the quality of care. This success needs to be understood as largely dependent on the existence of a clear pro-poor health strategy and the strong stewardship role played by the MoH (LSHTM 2007).

War and political upheaval in Cambodia left the primary health care system unable to deliver services of adequate quality: basic services such as immunisation were not provided and the child mortality rate was very high. The MoH contracted NGOs to provide PHC to rural populations in several districts. Three mechanisms of health care delivery were used:

1. Contract-out: in which the contractors had complete management responsibility for service delivery including hiring, firing and setting wages; procuring and distributing essential drugs; and organising and staffing public health facilities.
2. Contract-in: where the contractors worked within the MoH system to strengthen the existing administrative structure and health care personnel with government-supplied drugs and consumables and a nominal budget supplement for staff incentives and operating expenses.
3. Government: in which the management of services remained with the government's District Health Management Team, the government supplied drugs and consumables and the same nominal budget supplement for staff incentives and operating expenses was provided to the contract-in districts.

NGOs were selected using a competitive bidding process and health care service indicators and goals for improving service and coverage: for example, all districts were mandated to target services to the poorest half of the population. Several research findings point to the success of this approach in terms of improvements in both efficiency and equity. There were large increases in the coverage rates of health services in all districts, but the contracted districts achieved much higher coverage rates. The immunisation coverage rate in the contracted-out districts increased from 25.3% in 1997 to 82% in 2003 (World Bank 2006, 62). Starting at comparable levels, contracted-out districts increased use of public health services (preventive and curative) to 1.7 contacts per capita, and contracted-in districts increased to 1.2 contacts per capita per annum. Non-intervention areas had an annual per capita contact rate of only 0.8. Immunisation rates increased in contracted-out districts by 158%, in contracted-in districts by 82% and in non-intervention areas by 56% (Bhushan et al. 2002).

Contractors were also more successful at improving the quality of services and the distribution of services was more equitable in their districts. Per capita annual public recurrent expenditure in NGO-contracted districts was considerably higher than that in the government districts, while private out-of-pocket expenditures in the contracted districts were significantly lower. The larger substitution of public for private expenditures in contracted districts than in government districts benefited the poor, and the overall efficiency of the health care system in contracted districts was greater than in the government districts (World Bank 2006, 62). Finally, 'improvement in efficiency appear[ed] to [also have led] to better access of health services by the poor, relieving them of the burden of health care expenditures' thus contributing to significant gains in equity (see also World Bank 2006, 62).

Pay For Performance (P4P)

P4P (or performance-based financing or performance-based contracting) is another innovative approach which relies on the power of external incentives to improve NGOs' or private agencies' performance in the provision of services, scale up existing services and improve quality (Newbrander 2007). The basic principle is: 'the better they do the job, the more NSPs get paid'. Because of the high level of auditing and monitoring systems required to ensure the veracity of the reported results – hard to achieve in highly politicised or conflict settings – this mechanism is

mostly adopted in post-conflict settings. The P4P could help to improve government leadership, strengthen institution-building and reinforce existing services by addressing the dysfunctional incentives that are created by reporting on inputs, rather than outputs and outcomes. P4P can also help increase the demand side if service users are included in assessments of service quality and are made aware of what level of health services they should be receiving (LSHTM 2004); it may also be a powerful tool for introducing accountability mechanisms. Finally, supporting P4P programmes may be a useful way of addressing the challenge of meeting immediate needs and building long-term capacity.

The system of contracting in Afghanistan is based on a P4P approach, implemented by the MoH together with its donors' partners to expand service delivery and the availability of drugs. This system has allowed the MoH to meet urgent needs and scale up services by delegating service delivery to NGOs on the basis of a system of financial and non-financial incentives, thus addressing critical issues such as training health professionals and obtaining drugs. The MoH has contracted one NGO for each province to implement a BPHS at PHC level, which includes maternal and newborn health, child health and immunisation, public nutrition, communicable diseases and the supply of essential drugs (Palmer et al. 2006). After a competitive bidding process, the Ministry awards a lump-sum contract to an NGO to achieve predetermined performance goals. If the NGO works well it receives a bonus; if not, then its contract is ended and another NGO is appointed for the province (Waldman 2007). This system seems to be working well, not only in terms of building national capacity, as it is leaving the stewardship function in the hands of the MoH, but also in terms of addressing immediate needs and scaling up health services. From 2002 to 2006, the percentage of the population with access to basic health services has increased from 5% to nearly 80% (Newbrander 2007).

In 1999 in Haiti, USAID introduced a P4P approach in an attempt to improve the effectiveness of Haitian NGOs. From the beginning, the main challenge was to develop a system based on attainment of goals without imposing an excessive burden in terms of monitoring and reporting requirements. Under the P4P system, at the end of a defined period performance was measured and a bonus determined. If NGOs failed to attain performance targets, they would lose 5% of the budget under the contract, but if they succeeded they could earn 5% more than the budget. Seven indicators were selected to measure performance, and a third party was contracted to measure baseline and an end-of-period performance. In this case the P4P succeeded in significantly raising immunisation coverage and in increasing the usage of contraceptive methods. Moreover, the focus on results and the possibility of earning bonuses inspired NGOs to question their models of service delivery and encouraged experiment and innovation, which included greater efforts to involve the community (Eichler et al. 2001, see also Eichler 2006).

3.2 Alignment and harmonisation

Alignment and harmonisation are long-standing problem issues and despite the importance of those activities, especially in fragile environments, this is an area where donors' efforts remain far from optimal (HLF 2004).

Alignment refers to the relationship between donor governments and partner governments or authorities: the issue of building national capacity is at the very core of the alignment agenda. Given that '[e]xperience across all developing countries shows that donor terms and conditions that fail to mirror national priorities do not result in more effective aid' (DFID 2005, 12), there has been an increased focus in international policy circles on finding ways to engage with aid and assistance in a way that parallels, and can be linked with, existing or emergent government partner priorities and systems (OECD/OCDE 2006, 6). This includes alignments of strategies or frameworks such as national planning, budgeting and accounting systems (HLF 2004, 6).

In contexts where there is political will and government entities can serve as partners, donors should fully align service delivery behind government strategies. However, in environments where country priorities and policies are regarded as inappropriate and ineffective, for example out-of-date or non-pro-poor health policies (such as a high concentration of health services in urban centres), alignment is more problematic. It may not a viable solution because of concerns about legitimising a particular government, or because of a protracted humanitarian emergency. In those cases, it is crucial to incorporate *built-in mechanisms for transition* from the very beginning of programming: 'the possibility of eventual transfer to the state, at least of the regulatory function, needs to be built into programme design' (DFID 2005, 23, see also Commins 2005). The

concept of *shadow alignment* may be especially useful in those contexts as it seen as a state-avoiding approach, *but future-proof*, as it uses resources, institutions, structures or systems that are 'parallel but compatible with existing or potential organization of the state' (HLF 2004, 21). The idea is to build on what is already there to avoid as much as possible the creation of a 'diversionary institutional legacy that can undermine or impede the development of a more accountable and legitimate future relationship between the people and their government' (HLF 2004, 21), with the aim of handing over to national authorities in the medium to long term (Christiansen et al. 2005, 43). 'Agreement on essential drug lists, treatment guidelines and planning criteria for investment in the health care network are examples of ways in which shadow alignment should operate for health, in the absence of standards determined by the state' (HLF 2005(a), 5).

Especially in cases where the central authority is unwilling, donors should consult with a range of national stakeholders in the partner country and seek opportunities for *(harmonised) 'partial alignment'*, which refers to alignment behind programmes in areas that have sufficient commitment and capacity in ministries, agencies or regional governments (HLF 2005 (b), OECD 2007, LSHTM 2007). The idea is that, if the central government cannot be a partner, then it is important to look elsewhere and find *pockets of willingness* at institutional levels other than the state: in this way donors may be able to build on the existing pro-poor political will in lower-level institutions and then work to scale up those initiatives and integrate them into government planning processes (Berry et al. 2004). A study commissioned by DFID on a community-driven programme – the Child-Friendly Community Initiative (CFCI) – demonstrates that this may be a good way of 'taking advantage of windows of opportunity'[8] and dealing with the challenge of supporting central or local institutions in fragile state interventions. The CFCI, which includes service delivery of immunisation and basic health care for women and children in Sudan, shows that it is possible to initiate strategic partnerships with institutions that are committed to a pro-poor agenda. In this case, given the low levels of willingness and capacity at the federal level, the CFCI has engaged institutions at the regional level that are still lacking technical and administrative capacity, but at least are more pro-poor than central government (Torres 2006) and therefore offer room for manoeuvre.

Harmonisation refers to the relationship between different donors and their effort to orchestrate their activities so that they are complementary (rather than competing) so as to make efficient use of resources, and reduce transaction costs and fragmentation (HLF 2004, 6, Newbrander 2007). Given that support to the health sector in fragile environments is a very popular initiative among donors, which in turn leads to a high number of agencies, the need to harmonise strategies and initiatives is therefore paramount (HLF 2004, 7, HLF 2005(a), 4). When alignment is not possible, for example when the central government is unwilling, then harmonisation becomes especially important (Christiansen et al. 2005). In those contexts it is imperative that donors harmonise their approaches to alignment, or 'harmonize to align', with the aim to 'enhance, not undermine, the emergence of country leadership and ownership' (HLF 2005 (b), 27, Christiansen et al. 2005). However, a review of the literature has pointed to the fact that harmonisation and the implementation of comprehensive initiatives is a highly problematic issue and donors' efforts on the ground are too often fragmented and carried out on an *ad hoc* basis, taking the form of parallel, largely independent activities.

Joint analyses

Joint analysis and assessment is another area that requires effective donor coordination. According to OECD, '[i]n order to improve the effectiveness of the activities of the different actors involved, they need to be linked to a set of broader, joint objectives. These objectives ought to be defined on the basis of joint analyses or assessments'. The emphasis on these joint assessments and a more integrated perspective is also important for ensuring that objectives balance the capacity of a donor country with the needs of a fragile state. It is therefore essential that, from the beginning, objectives are linked to planning, implementation, co-ordination, monitoring and evaluation. If such objectives can be clearly defined, this will also be helpful in terms of donor co-ordination and harmonisation (OECD/DAC 2006). In East Timor, for example, a Joint Assessment led by the WB and together with members of five donor countries, UN agencies, the European Commission and the ADB, identified the overall needs for health sector rehabilitation. This approach minimised duplication of effort, facilitated targeting of funding towards priority health sector activities, and led to the implementation of the Health Sector

[8] AusAID 2006 White Paper.

Rehabilitation and Development Programme I (HSRDP I) (Alonso and Brugha 2006, 210).

Sector Wide Approaches (SWAps)

SWAps are another mechanism that can be used for harmonising donors while pursuing alignment with government priorities (Newbrander 2007, 26). The ideal model of a SWAp seeks to integrate government and donor activities within a sector so that all funding for the sector supports a single policy and expenditure programme. The government and donors agree at a strategic level on the resources and policies for the specific sector, in a way that is consistent with the national budget and economic strategy. Procedures for disbursement are then harmonised and funds pooled. This approach can be understood as a clear departure from project-based, donor-led interventions which, as discussed above, inevitably lead to a fragmented response. Instead, SWAps aim at enhancing coordination and harmonisation of donors' activities under government guidance, which in turn leads to uniformity of government-funded and donor-funded activities, greater efficiency and equity, decreasing transaction costs and the creation of sustainable health policies and systems. In fragile environments alignment is very difficult to achieve. Preparing and implementing SWAps is a very long process, and because of governance weaknesses and deficits the recipient government often finds it difficult to orchestrate donor coordination, especially when several donors are involved (World Bank 2004, 213, Newbrand 2007, Perks et al. 2007). SWAps have been used in fragile states such as East Timor, PNG and the Solomon Islands.

In post-conflict East Timor the early implementation of a SWAp laid the basis for appropriate coordination and increased legitimacy by placing '[T]imorese at the centre of the process, with the international actors supporting them with technical and financial assistance' (Alonso and Brugha 2006, 209). An Interim Health Authority (IHA, which could be viewed as the nascent MoH) was established, composed of national Timorese and international UN staff and responsible for coordination of all health sector activities. The HSRDP I (see above), led by the WB, aimed at restoring access to basic services and developing health policy and systems, and was created *within* the IHA so as to be implemented as a comprehensive programme rather than as single health projects (Alonso and Brugha 2006, 210).

Since 1999, the government of PNG has been pursuing a SWAp through the establishment of the Health Sector Improvement Program to provide a mechanism for pooled funding. AusAID has supported this process through a phase-out of project aid for health, channelling recent support through a Health Sector Support Program and establishing a Capacity Building Service Centre. This approach offers an excellent opportunity for joint funding, donor co-ordination and facilitation of a partnership approach. However, the government has struggled to lead the SWAp, especially at provincial levels, and not all donors have participated. Tensions between major donors are an important constraint to harmonisation (Newbrander 2007).

Transitional Results Matrix (TRM)

In post-conflict or transitional countries, simple integrated planning tools have been developed, such as the TRM developed by the LICUS unit at the World Bank. This is an integrated multi-donor coordination tool that can help partner governments to foster better donor coordination and improve the coherence of the international response, focusing on the development, security and diplomacy components of a transition from fragility to stability (HLF 2005 (b), WB 2005(b)). The advantage of this instrument is that it forces consideration of synergy and interaction, and specifies results within an overall development strategy, but within a relatively short time horizon (HLF 2005(a), 5). The TRM has been implemented in East Timor, Liberia, the Central African Republic, Sudan and Haiti.[9]

3.3 Instruments and funding mechanisms[10]

The challenge in addressing immediate health needs while building long-term capacity is reflected in the funding mechanisms for health service delivery. In states that have recently emerged from armed conflict or violent insecurity, '[t]he need for instruments that will more effectively link humanitarian relief with development is a longstanding issue' (HLF 2005(a), 7, Patrick and Browns 2007). Addressing the funding gap between relief and development and 'a commitment to reliable longer-term funding … is vital for sustainable systems' (OECD/OCDE 2006, 38). A key issue in this regard is the need to ensure sustainability in the long term: it has been argued that 'a crucial condition of maintaining the

[9] In the literature reviewed no comprehensive case studies of this approach were found.

[10] For a comprehensive review of instruments and funding mechanisms in fragile states see Leader and Colenso 2005.

sustainability of policy-based approaches to international assistance [is to ensure] that policy-makers and politicians feel that they own their own policies' (Foltz 1994 in Macrae 1995). Donors need to pay special attention to the way funding for a health service is provided in fragile states.

Budget support

Budget support (and PRSPs) is an unpopular aid instrument in fragile states: poor expenditure management and weak relationships of accountability in these environments inevitably lead to poor levels of trust between donors and recipient governments. However, as DFID suggests, even when the government as a whole is very fragile, but there is some degree of willingness, one option may be to ring-fence budget support to particular ministries (DFID 2005, 19). There is also some experience of using highly earmarked budget support, either for accredited health service providers or to generate demand for services (e.g. vouchers for free access to specific services). Donors have been most willing to use these mechanisms when, for example, a trust fund is in place, operated by an independent financial management entity that handles resources on behalf of the state and donors, such as through multi-donor trust funds, as discussed below (HLF 2004, HLF 2005 (b), Leader and Colenso 2005, Newbrander 2007).

Dissatisfaction with the side-effects – fragmentation and projectisation – has led donors to experiment with new aid instruments such as Multi-donor Trust Funds, Social Funds and Joint National Programmes. These instruments, discussed below, 'are used to pool funding in post-conflict reconstruction settings usually to deal with exigencies of state building and the massive requirements of reconstruction against absorption bottlenecks' (WHO 2007, Module 8).

Multi-donor Trust Funds (MDTFs)

MDTFs have been used for channelling aid in transitional countries such as East Timor, Afghanistan and Iraq (see *Module 8* for a discussion). MDTFs function as a proxy for national budgets and allow donors to provide 'budgetary support to countries where fiduciary risk is high while simultaneously building the capacity of the state to manage and control its own budget' (DFID 2004). Two problematic issues have pushed the international donor community to explore instruments like MDTFs: 1) the transitional funding gap between humanitarian assistance and development assistance, which typically leaves the transition from conflict to post-conflict under-funded (LHTM 2007, HLF 2004, 15, Newbrander 2007, Collier and Hoeffler 2002) b); and 2) the inherent financial management risks donors incur when they engage in fragile states.

There are several advantages in using MDTFs. In contexts where there is limited capacity, MDTFs can facilitate shared priorities and responsibilities for execution between national and international institutions and can serve as a mechanism for coordinating funding of reconstruction activities in line with agreed priorities with the government (OECD 2007, DFID 2004). MDTFs channel most funds to the public sector (e.g. to pay civil servant salaries), and most resources go to primary service levels in service delivery, thus potentially reaching groups most in need, reflecting a positive distributional profile (Scanteam 2007 (a)). They also allow for the financing of high-priority projects, identified within a common strategy and a common development objective under the direction of the government, while at the same time building state capacity to manage and control the budget (DFID 2004). Thus, 'multi-donors trust funds can reduce the tendency to projectization' (Leader and Colenso 2005).

The Afghanistan Reconstruction Trust Fund (ARTF) has become the main instrument of support to government expenditures, including funding salaries for health workers, and the key funding mechanism for donors. A review of DFID interventions in fragile states points to several elements of success of the ARTF: the fact that it is overseen by a 'Management Committee responsible for reviewing progress and making key management decisions' and the presence of a 'Monitoring Agent to ensure fiduciary management … has increased donor confidence and encouraged significant levels of funding'. The separation of recurrent and capital costs from investment projects through the so-called 'ARTF windows' has allowed donors to directly finance local and district-level programmes which are identified by the government as high priority. These activities, either in the form of SWAPs or stand-alone projects, allow critical short-term needs to be addressed while also contributing to a broader strategy, as they are placed *within* an overall framework and strategy for development (in this case led by the government with the support of donors). Government capacity is strengthened as financing programmes through the ARTF requires line ministries, such as the MoH, to 'prepare projects to international standards, whilst meeting international standards for

procurement and financial management' (DFID 2004, 47–50).

Despite the theoretical advantages, the real-world experience of MDTFs has not been wholly positive. A review of the MDTF[11] in South Sudan commissioned by the WB and other donors concludes that overall performance has been unsatisfactory. The government and donors have pointed to the fact that disbursement rates are too slow, and that WB procedures are too heavy and inappropriate for such a low-capacity environment and lack the flexibility required to adapt to the local context. For example, government staff often did not understand WB procedures, in many cases did not have the systems or personnel in place to meet requirements and consultations with government officials on project design were often perceived as insufficient by local stakeholders (Scanteam 2007 (b)). Thus, despite the potential advantages, poor management and implementation can undermine even the most progressive instruments.

Joint Programmes

Joint Programmes[12] are innovative and evolving instruments where the use of pooled or basket funding supports single – often national-level – programmes, projects or agencies. Joint Programmes allow donors to build capacity at the national level, by taking advantage of national strategies and approaches, while engaging in localised implementation. Because Joint Programmes are designed to be compatible with national policies and/or systems, they may be more easily absorbed into government policies and structures than the single projects that often characterise the health sector. This approach offers opportunities to increase donor harmonisation (Leader and Colenso 2005) and alignment (DFID 2004). It also enables donors to work in partnership with civil society organisations to scale up services (DFID 2004).

The Joint Programme for HIV/AIDS in Myanmar is widely discussed as a successful example in a fragile state characterised by low willingness and low capacity. Donors such as DFID and the EC, who are reluctant to provide aid to Myanmar because of its unwillingness to introduce serious policy reform, are funding the Joint Programme through the Fund for HIV and AIDS in Myanmar (FHAM), a multi-million-dollar pool provided by several donors and managed by the UN, which is seen as a legitimate route for engagement. The fund is used to support projects proposed by the government, national and international NGOs and the private sector. Projects are selected for funding on the basis of the value and cost-effectiveness of the proposed work, and the capacity and track record of the potential implementer. Proposal and selection processes are open and transparent, and designed to maximise the use of resources in the light of national needs and international best practice. The Joint Programme operates as the *de facto* National AIDS Implementation Plan. It depends on the active agreement of implementing partners (including government departments and structures such as the National AIDS Programme) to share information, coordinate planning and activities and contribute to management and advisory bodies. The FHAM/Joint Programme has been successful in allowing development stakeholders to work together with government agencies in a difficult political environment where the government is perceived by many stakeholders to be illegitimate (DFID 2004, 57). Moreover, in Myanmar pooled funding has allowed donors to work in partnership with civil society organisations and to scale up the response mainly because of 'in-country capacity' such as national, local and government-organised NGOs, UN agencies and government agencies including the National AIDS Programme, and because of the compatibility with national policies and systems (*Ibid.*).

Health-Related Global Funds

Global funds transcend national barriers and involve public–private partnerships at the global level to address a specific health problem. These funds involve developing policies for the global procurement and distribution of commodities such as vaccines and essential medicines, and provide funding on a project basis directly to service providers. They have the potential to provide predictable financing, linked to policy dialogue and technical advice, in support of government-led approaches. One danger with these instruments is that, because they channel resources outside the regular budget process, they may create tensions between policy-makers in charge of the overall spending programme and provider organisations. This risks distorting national policies and chains of accountability, increasing transaction costs and creating separate planning, financing and delivery channels (World Bank 2004, 205; Leader and Colenso 2005). These initiatives have been

[11] For an in-depth review of post-crisis MDTFs see Scanteam 2007 (a); for a collection of in-depth case studies on MDTFs including Afghanistan, East Timor and Sudan see Scanteam 2007 (b).

[12] For an in-depth analysis of Joint Programmes and MDTFs see Leader and Colenso 2005.

criticised for leading to 'unnecessary duplication and overlap with each other and with country assistance programs, along with gaps, confusion, and waste, raising anew the perennial aid effectiveness issues of priorities, ownership, consistency of goals, and accountability for results' (Lele et al.). In Uganda, for example, the MoH insists that resources should be channelled through the regular budget process rather than through the global funds. The latter are seen as undermining the country's attractiveness to donors; Uganda is highly dependent on its reputation for sound macroeconomic management (World Bank 2004, 205).

The simultaneous use of different funding mechanisms and instruments in fragile states is often inevitable and 'there is rarely agreement on what form of lending or granting instruments be best, or, if there is agreement, there are domestic obstacles that prevent all donors from participating in a single funding scheme' (Waldman 2006 (a), 8). For example in the DRC, a typical range of mechanisms is found in the health sector: direct payments to the government, supported by ADB; disbursement to the government though a fiduciary agent and a state-related, parallel management unit, supported by the World Bank; and state avoidance – i.e. direct contracts between donors and private contractors with some participation of the state in programme design, supported by USAID (*Ibid.*). Donors' efforts to harmonise and 'the frank and open sharing of plans, programs and objectives' (*Ibid.*) in these contexts is therefore key.

3.4 Approaches to reaching the poorest[13]

A variety of critical issues may significantly limit or even prevent pro-poor access to health services. Issues including horizontal inequalities, social exclusion, real or perceived discrimination on the basis of gender, ethnicity, religion, caste etc. (Stewart 2001, Berry et al. 2004); geographic location, such as remote areas, urban slums and conflict zones (HLF 2004, 11, Berry et al. 2004, Kirk and Standing 2005); and financial barriers, may all significantly limit or even prevent the poorest from accessing health services. The literature therefore points to the importance of reaching the poorest in service delivery interventions in fragile states. This is a very broad topic and a full discussion is beyond the scope of this analysis, so only selected lessons and approaches are presented below.

Supply-side issues

Traditional models that rely on universal distribution have increasingly been questioned in fragile states (and in developing countries in general), particularly in view of evidence that standard models of state-provided health services tend to result in widespread inequities, with wealthier groups receiving a disproportionate share of public health services at the expense of the poorest (Kirk and Standing 2005). There is therefore a renewed attention to **targeting** as an effective way to reach vulnerable groups (Kirk and Standing 2005). When fragility is strictly connected to the 'marginalization of some ethnic groups (or in the post-conflict scenario where violence has been due to the discontents of one or more marginalized segments of the national population)' (Waldman 2006 (a)), targeting health access to those groups may contribute to promoting peace. In this way, the provision of health services can also be understood as preventing states from slipping into violence (Newbrander 2007, 1, LHTM 2007). The barring of the Kosovar population from accessing public health services in Serbia is frequently cited as an important factor that contributed to the war in the Former Yugoslavia (Waldman 2006 (a)). Similarly, DFID emphasises the strategic importance of enhancing access to basic services for marginalised groups: '[i]n fragile states a basic level of commitment to poverty reduction is to provide broad-based services to the population without institutionalized discrimination directed at particular groups. This is an area where donors can help build capacity at the same time that political commitment is secured' (DFID 2005, 15).

However, the issue of equity in fragile states is problematic: while equity should be the clear objective of long-term developmental interventions so that 'social, geographical and financial barriers are deliberately minimized' (Odaga 2004), in humanitarian assistance, equal access to health care is often an elusive goal, mainly 'because of security, funding and logistic constraints' (HLF 2004, 11). An example is provided by the USAID approach in fragile states, which emphasises stability and conflict management; support to health service delivery is therefore subordinate to the broader objective of enhancing stability. In implementing this strategy, USAID has followed the principle that 'in

[13] For a comprehensive and in-depth review see Eldis dossier 'Meeting the health related needs of the very poor' at http://www.eldis.org/index.cfm?objectid=D6550214-9395-F4E5-F886B3F3BF31C684.

rebuilding states, and especially those where the prevention of renewed conflict is an important consideration, equity may not have the highest priority' (Waldman 2007, 4). In Southern Sudan, US foreign policy was centred on supporting the implementation of the peace accord. In turn, the health strategy pursued by USAID became aligned with foreign policy as the focus became on the southern and western parts of South Sudan, which were at greatest risk of hostilities and which had the most destabilising potential. Despite the fact that health services in these areas were relatively more advanced than in other areas, USAID shifted the support of health services away from the very poor, disadvantaged communities in other areas of greater need to southern and western areas perceived as transitional, highly volatile areas. In this way, the political imperative of US foreign assistance led to the pursuit of a strategy that paid less attention to equitable distribution of health services in the short term, to increase the probability of achieving lasting peace, which in turn may lead to the achievement of health equity in the longer term (Waldman 2006 (a) and 2007). This strategy was also pursued in the DRC (Waldman, 2006 (b)).

As discussed above, choosing whether and to what extent partnering and support should focus on central government institutions or on district, provincial and local-level institutions is a key challenge in donor engagement in fragile states. **Decentralisation** is a broad topic and a full discussion is beyond the scope of this review. It is important however to highlight the underlying rationale: by bringing decision-making closer to the people, decentralisation is expected to deliver services that better address local needs (World Bank 2006). However, decentralisation has had mixed results in health. Decentralisation is essential for public participation, but the administrative readiness for delivering basic services at the local level remains questionable in many cases. Transferring the provision function to local governments has often overwhelmed them, and the transfer of ownership of assets such as hospital and clinics has created incentives for rent-seeking by local elites (World Bank 2006). 'Successful decentralisation implies a strong central state, a functioning public sector, a vibrant civil society, the respect of the law, the capacity to peacefully manage conflicting interests, by definition conditions conspicuously absent in a protracted crisis' (WHO 2007, Module 3).

In Afghanistan, for example, central authority is limited and in places highly compromised, and there is no standardised practice for health service delivery, such as user fees, drug procurement systems and deployment of community health workers. Rather than a transfer of effective managerial responsibility, a principle embodied in successful decentralisation approaches in the West, the situation in Afghanistan looks more like fragmentation than decentralisation (Palmer et al. 2006).

In PNG, strong leadership and political will at the central level has not permeated down to lower levels to the extent needed. There are problems in coordination, both among departments and between central and decentralised levels, as well as inadequate monitoring and supervision. 'Issues that the PNG case highlights, and that need to be addressed, include (i) capacity building at the regional level as well as central level for monitoring, supporting, and coordinating decentralized efforts; (ii) improved fiduciary standards; and (iii) effective personnel policy that provides incentives for performance at all levels'.[14]

Demand-side issues[15]

In fragile states, especially because citizens' trust may have deteriorated because of poor access and low quality services, '[g]enerating demand for health services is a critical aspect of rebuilding the health sector' (HLF 2004, 14). Working through civil society organisations, seeking to empower communities and enhancing their voice and participation to demand and control services from local government are seen as crucial steps in generating demand for health services (HLF 2004, Berry et al. 2004).

Community-based approaches (CBAs) can be used to address non-financial, demand-side barriers to health service delivery. They can empower communities, setting up local governance structures and strengthening accountability mechanisms. A key issue to remember is that, while CBAs may be effective in responding to the needs of the poorest, they need to be complemented by an overarching framework that defines standards to ensure equity in the provision of health services (Slaymaker et al. 2005). As the discussion so far has highlighted, civil society organisations cannot be substitutes for the state and they are not equipped to scale up services to the whole population because of their

[14] http://siteresources.worldbank.org/INTPAPUANEWGUINEA/Resources/case-summ-PapuaNewGuineaSriLanka-Health.pdf.

[15] For a comprehensive review see Slaymaker et al 2005

limited coverage (Commins 2005). Pre-requisites for these schemes to work include: presence of an external organisation with the capacity to design, manage, implement and sustain the scheme; strong community trust in the implementing organisation; and availability of local health providers capable of providing essential health services to a basic standard.[16] Box 1 below summarises some key opportunities and challenges to CBAs in fragile environments.

Box 1: Opportunities and challenges to community-based approaches

Opportunities

Builds local capacity and can strengthen voice
Quick disbursing and provides tangible benefits to communities
Flexible with respect to project focus
Communities drive the process and have control
Communities have a stake in managing project funds carefully

Challenges

Requires some institutional capacity at the community level and may impose disporportionate demands
Going to scale requires a large number of project staff who speak local languages and understand local social and political dynamics
Care must be taken to make the link between sectoral work and community-based work
Elite capture of resources is possible so monitoring mechanisms are needed

Berry et al. 2004, 23

The Community Managed Model in Puntland, Somalia, implemented by the World Bank in collaboration with the Somali Red Crescent Society (SRCS) provides an example. A community, represented by a community-appointed health committee, assumes joint responsibility together with the implementing organisation (SRCS), the district and regional health authority, for the management and financing of health services.[17] A joint WB and SRCS evaluation concluded that the programme 'successfully improved the health condition of the most vulnerable (women and children) as well as men and the elderly, living in proximity to the clinics assisted (and in some catchment areas)'. Similarly, the DFID evaluation of the CFCI (see above) in Sudan concluded that such an approach was successful in building capacity at both the community and local government levels and was useful for addressing demand-side barriers through community mobilisation (Torres 2006).

NSPs often play a crucial role in health service delivery in fragile settings, which makes donor engagement with these actors necessary and inevitable. In East Timor at the height of the conflict, the contribution of NGOs was crucial in controlling mortality thanks to their efforts in re-establishing 'minimum primary care services, provision of drugs and organization of emergency referrals' (Alonso and Brugha 2006, 210). In PNG and the Solomon Islands, churches have a long-standing tradition of health service delivery. A report commissioned by AusAID concluded that, in PNG, churches 'have a significant potential to contribute to wider societal change processes … and function as a partner to government in service delivery', and are widely perceived as legitimate actors (Hauck et al. 2005, 20). The coordination and management of NSPs requires attention, while keeping the government at the centre. One mechanism could be to 'set up joint NSP-donor-government discussion on 1) indicators on impact of services and 2) ways to connect service provision with public sector strengthening and accountabilities to local civic organizations' (OECD/OCDE 2006, 23).

Reducing the costs of accessing services

The rationale underlying this strategy is to address financial barriers in order to increase access to health services among the poor. There are many methods to reduce costs of access, but we concentrate here on user fees and social funds. Advocates for the removal of *user fees* in the health sector argue that they adversely impact the utilisation of services by the poor, thus countering the benefits that for example SWAPs or BPHS may provide (Odaga 2004). However, it is important to keep in mind that, in many fragile states, where NSPs are major providers of services, and lack of government capacity makes effective regulation virtually impossible, this may not be a feasible option. More feasible solutions may be to increase the amount of disposable income that the poor have access to, for example through cash distribution or cash for work programmes (Berry et al. 2004). The WB points out that, in some cases,

[16] http://www.eldis.org/go/topics/dossiers/meeting-the-health-related-needs-of-the-very-poor/health-related-strategies-for-reaching-the-poor/community-based-health-financing-schemes

[17] http://siteresources.worldbank.org/INTLICUS/Resources/388758-1187275938350/4101054-1187277377932/PCFONote3.pdf

the introduction of user fees may be an effective way of replacing unofficial charges, which in fragile states and generally in developing countries is a widespread practice within the public sector and constitutes a form of 'rent' for health services. When user fees replace unofficial fees and their revenue is retained by health facilities to finance essential supplies and provide some incentive to health workers, this intervention is likely to be successful (World Bank 2004, 143). However, there is evidence from several studies in Africa that the introduction of user fees has not been accompanied by the creation of an effective exemption system and has often driven the poor out of the public sector to the private sector. It seems therefore that 'those schemes only work when they are accompanied by effective exemption, community financing and insurance systems' (Moran and Batley 2004, 14). According to Waldman (2006(a)) especially in the immediate post-conflict period there is a strong case for providing health services free of charge to the population and for heavily subsidising the provision of drugs. The decision ultimately rests with donors because, if the final user does not bear the cost of the services, then either donors or the government will have to do so. For example in DRC the MoH and some donors have been supportive of user fees even if there was clear evidence that paying for health can be a cause of poverty.[18]

Social funds are one of the World Bank's preferred instruments[19] and are increasingly being used in fragile states contexts, especially in post-conflict states as part of broader reconstruction strategies. Generally, social funds entail the provision of block grants to communities (devolution), to be spent on micro-projects selected by the community (participation), but which have to meet specific criteria (both process criteria and design criteria) (Leader and Colenso 2005, Ranson et al. 2007). The main advantages of social funds in fragile environments include: improving participation and strengthening the relationship between communities and local government; enhancing state legitimacy as grants are seen as coming from the state; adaptation to the local context thanks to design flexibility; and providing a coherent framework for national coordination among donors. Social funds have been criticised on a number of grounds, including the possibility that they may fail to build local and central government capacity, may suffer from poor coordination in the targeting of service delivery interventions and may create a parallel structure, possibly undermining the state's role in service delivery (Berry et al. 2004, Leader and Colenso 2005, DFID 2004, World Bank 2005, Christiansen et al. 2005).

The National Solidarity Programme (NSP) in Afghanistan was designed in 2003 with the support of the WB as a key part of the reconstruction process. Communities elect a community development council (CDC) through secret ballots. The community is responsible for designing and implementing projects, for which each community receives training on financial procedures and then a block grant. Early findings point to a number of positive outcomes. The NSP has vastly expanded the scale of NGO activities at the national level, thus reducing fragmentation and projectisation; it has increased the amount of money spent by communities on reconstruction; it has contributed to changing village perspectives of the central state, and has allowed greater involvement of women in local decision-making. Especially regarding this last point, the NSP has been designed to allow the optional creation of women-only CDCs.[20] Among other activities, these put forward ideas for women's projects based on consultations with women in the communities. Women's needs are generally related to the health and education of their children, as well as health and hygiene and reproductive health, including the training of local midwives. A recent evaluation has concluded that there are indications in many communities of change including in some communities a growing recognition on the part of men of the need to include women in reconstruction and development processes (Boesen 2004, OECD/OCDE 2006).

[18] In the DRC the cost of an emergency procedure such as Caesarean section is $60 or more in areas where 80% of the population earn less than $0.20 a day (Waldman 2006(a)).

[19] The World Bank calls social funds 'Community Driven Development or Reconstruction (CDD/R)'.

[20] Because of the sensitivity of women's participation in the context of Afghanistan and in order to avoid endangering the overall programme, women's participation is not mandatory in the NSP.

Section 4: Conclusion

Health indicators in fragile states are the worst in the world, representing a tragedy of human suffering and lost opportunity. Both from a humanitarian and a developmental perspective, finding ways to promote health and tackle disease in such contexts is imperative. This review has highlighted some of the ways in which international actors can best approach that task.

The paper has reviewed the international literature on health sector delivery in fragile environments. It covers some of the key challenges facing donor engagement in pro-poor health service delivery in fragile states; the paradigm shift in donors' engagement in fragile states; and donors' approaches to supporting health service delivery, specifically discussing approaches and strategies, alignment and harmonisation, funding mechanisms and possible ways to reach the poorest.

A key theme that has emerged from a study of the literature is that there is no *single* mode of engagement in fragile states, and donors' interventions in the health sector should be adapted to the reality on the ground. A sound political analysis of the context, which takes into account key aspects and determinants of state fragility and the current stage of its evolution, should underpin donors' responses.

This review has also pointed to the crucial issue of involving, rather than bypassing, state institutions in health service delivery interventions. Donors' engagement in fragile environments should aim to build competent and accountable health systems to ensure effective service delivery in the longer-term, while addressing basic health needs. However, the review confirms a central issue that is widely discussed in the literature: building state capacity is especially problematic in these environments precisely because of the inherent governance deficits that characterise fragile states. Donors' responses therefore will necessarily be fraught with challenges, difficult choices and trade-offs. Indeed 'there will be a continuing dynamic between reducing immediate vulnerability; achieving specific health outcomes; building a more lasting and equitable health system; and building the capacity of civil society' and of the state (HLF 2005(a), 3).

Moreover, this review has pointed to the key role that NSPs play in pro-poor service provision and in scaling up, in terms of expansion of the coverage and availability of health services. NSPs' contribution is seen as especially relevant in the health sector, as in many low-income countries health services are predominantly non-state at the point of delivery. Pro-poor health service delivery interventions should therefore aim to harness NSPs in ways that do not undermine state institutions. One possible way to do this may be through contracting. As the examples of Afghanistan and Cambodia demonstrate, contracting arrangements between the state and NSPs allow the state to retain stewardship and oversight functions, by setting policies and regulating health service provision, while leaving the actual delivery of health services in the hands of NSPs.

Appendix 1: Working definitions

This paper understands 'fragile states', 'primary health care' and 'health systems' in the following way:

Fragile states
According to the widely used OECD-DAC definition, states are fragile when governments and state structures lack the capacity – or in some cases political will – to deliver public safety and security, good governance and poverty reduction to their citizens. This review focuses on countries where the ability of the state to provide basic services is seriously compromised by the weakness of state institutions, lack of capacity and/or disruption related to ongoing or recent armed conflict or violent insecurity.

Primary health care
The WHO definition of primary health care (PHC) is based on the seminal Alma Ata Conference of 1978: '[p]rimary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford'.[21] In this review, the delivery of effective PHC is understood as resting on the following core principles:

- universal access to care and coverage on the basis of need;
- commitment to health equity as part of development oriented to social justice;
- community participation in defining and implementing health agendas.

(Adapted from WHO 2003)

Primary health care should include at least 'education concerning prevailing health problems and the methods of preventing and controlling them; … maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs' (Alma Ata 1978). The range of related services is potentially very wide, and the examples used in this review cover only a part.

Health systems
According to WHO, a 'health system comprises all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health.[22] Most national health systems include public, private, traditional and informal sectors (see also WHO 2000, 1). The basic building blocks of a health system stewardship, human resources, health facilities, equipment and drugs, financial resources and management systems provide an overall guide for what needs to be addressed by donors engaging in health system support and development in fragile states (HLF 2005). In this review, an effective health system based on primary health care is understood as:

- building on principles of universal access, equity and community participation, thus ensuring effective provision of services to poor and excluded groups;
- taking account of broader population health issues, reflecting and reinforcing public health functions; and
- continuously evaluating and striving to improve performance.

(Adapted from WHO 2003, 108).

If the main *objective* of a health system is to improve people's health, health service delivery is the main *function* that a health system performs (WHO 2000).

[21] http://www.who.int/topics/primary_health_care/en/.

[22] http://www.who.int/topics/health_systems/en/index.html

Appendix 2: Sources, search methodology and bibliography

Sources and search methodology

The documents for this review were collected from the following English-only sources:

Published literature. Papers were identified through Google and a systematic search in specialised academic databases, such as Pubmed. Key words that were used in the search include: fragile state*, state fragility, health service*, health service delivery, health service provision, conflict, post-conflict. The websites of multilateral and bilateral donors (AusAID, USAID, DFID, WB, OECD) were searched, in addition to the websites of organisations and international forums concerned with health systems and health service delivery in developing countries, such as BASIC (funded by USAID) and the Health Resource Centre (funded by DFID). Priority has been given to papers published since 2004.

Grey literature. Documents provided by AusAID were reviewed and (where appropriate) included.

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