WHY IS IT AN EMERGING ISSUE?
A sixth of the world’s population live in fragile states (1), where mortality remains very high and life expectancy low. By 2015 it is estimated half of those in extreme poverty will be living in fragile states (2). Many countries have been labelled ‘fragile’ due to their status as conflict, post-conflict or states with very low capacity to deliver services. When looking at solutions, there is no ‘one size fits all’ course of action. A differentiated approach is needed.

HEALTH SYSTEMS IN FRAGILE STATES (2)

The challenge of meeting health needs for the world’s most vulnerable populations.

By Nigel Pearson

*This is the second part of two briefs looking at the delivery of health care in states affected by conflict and fragility.

A DIFFERENTIATED APPROACH
When looking at solutions, each state, and sometimes each province within a country, requires unique prescriptions for their health systems as part of overall development, poverty-reduction and state-reinforcing care plans.

A first step is to undertake accurate assessments and analysis which can enable such a differentiated approach to health systems strengthening to be adopted in each country. Governments may encourage provinces to have greater flexibility in design and more autonomy in implementation. International agencies may chose to invest more in the most
challenging operating environments (COEs) to overcome the increased risks of working in them.

Each country requires a tailored approach, adopted and led by the national government with support by partners, or directly by regional authorities with partners in areas within a country where collaboration is no longer possible with a central government due to conflict or political factors.

ADOPTING A STATE-REINFORCING APPROACH

International agencies should identify weaknesses that need addressing in the health system and work within a framework that will create sustainability and reinforce state capacities at all levels.

At the same time, it is important to develop mechanisms that increase the responsiveness of states to meet the expectations of citizens, and promote local agency at household and community level and reinforce legitimacy. (see: Dynamic model of a sustainable health system in Brief 1).

They should identify indicators to show the effect of the programme on state-building processes, while promoting global health governance norms. The New Deal for Engagement in Fragile States puts state building as a central objective. If the health system programme reform is then adopted as a core component of a New Deal or a Poverty Reduction Strategy (3) this in turn galvanises political leadership for the health sector (4).

Outsourcing, or contracting-out services is possible within a state-reinforcing model. The legitimacy of the state may depend more on how services are provided than on who delivers them – delivery by non-state providers (such as

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1 A country-by-country approach was adopted in 11 countries by the Vaccine Alliance (GAVI) in 2012 for chronically unstable countries, affording greater flexibilities, increased technical assistance, easier reprogramming of funds and intensified support. See: http://www.gavi.org/about/governance/programme-policies/gavi-policy-on-fragility-and-immunisation/

2 See Peacebuilding and Statebuilding Goals of DAC-INCAF; International Alliance and g7’s statements at: http://www.newdeal4peace.org/
international NGOs) may not reduce legitimacy if state health structures are used. It may in some scenarios be better for the state to outsource quality service delivery than deliver services directly, while reinforcing its regulating and monitoring roles (5).

Innovative public-private models may be created, bringing the private sector within the health ministry’s policy and regulation framework.

The World Bank promotes performance-based financing in health delivery, with promising results in some countries (6) of increased coverage of key interventions which are monitored via the Health Results Innovation Trust Fund (7).

To promote legitimacy, development agencies should aim for equitable service provision, supporting improved public financial management at all state levels and promoting active involvement of citizens in accountability mechanisms (5).

SECTOR-WIDE AND SYSTEM-TARGETED SUPPORT

Ideally national health authorities set policy in National Health Plans, working collaboratively with international agencies in sector-wide approaches (SWAp) at central, provincial and local levels. Capacity is often built up with separate health system strengthening (HSS) grants, or with HSS components within disease-focused grants.

It is of particular importance that agencies support the building up of human resources for health (HRH) capacity across the spectrum of policy, recruitment, training, deployment and retention.

Agencies may need to make significant investments in public financial management (PFM) to foster accountability and effective use of resources and promote the production of health outcomes.

For an example of an effective public-private partnership, see HealthNet TPO’s programme in Uruzgahn province of Afghanistan at: http://www.healthnettpo.org/en/1519/public-private-partnership-ppp-project.html

Government and agencies work together to increasingly diversify income for health delivery, harnessing community, private, diaspora, district, provincial, central and external sources.

Programmes that have used parallel procurement systems increasingly need to collaborate around common procurement and supply chain management (PSM) for medicines and health and nutrition products.

The lack of quality data is a great impediment to effective planning, and all agencies need to allow some funding in support of a computerised national health information system (HIS), whether they are working with the central ministry or with regions or districts. Critical investments are needed in any programme to ensure at least some reliable data is forthcoming with indicators to measure programme performance. Some of this investment needs to be in technology, with smart phones or tablets at times more cost-effective and appropriate than laptops for data recording and transmission.

In the most challenging operating environments (COEs) it may not always be possible to work through centralised systems. The country may be in conflict, with different factions controlling different parts of the country. Corruption within a ministry may make it difficult initially to channel funds through the ministry. In these cases, the need to work on PFM systems is still imperative\(^5\) (8), while refraining from using government systems

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4 The WHO System of Health Accounts (SHA) framework is available for institutionalising the transparent collection of annual health expenditure data. SHA can be used to track all health spending in a country allowing comparison of health expenditure between different entities over time, contributing to evidence-based policy making.

5 PFM investments in Afghanistan for example have enabled the MoH to manage contracts effectively. See Rubinstein L. & Haar R, 2012.
to distribute donor money until measurable PFM indicators and audited public accounts demonstrate transparency and accountability.

Agencies can collaborate in supporting a unified PSM system across health districts even if conditions in a country or region do not initially allow a centralised PSM to function. In this case agencies use flexible interim mechanisms (such as international procurement of medicines and supplies or the use of regional pharmaceutical retailers) and organise transport to regions, meanwhile building capacity for future centralised procurement.

International agencies have to be continually innovating in the most challenging operating environments (COEs). While looking for models that already produce results and identifying partners with proven track records in the particular environment, new methods need to be innovated and piloted, and the learning experience systematically documented and shared. There needs to be flexibility in budget timelines to allow innovations and adaptations to be incorporated as lessons are learnt and impact from certain innovations proven.

ESSENTIAL PACKAGES FOR EFFECTIVE DELIVERY

An essential package of health services (EPHS) uses standard sets of evidence-based health interventions across health facilities in a country that together target and can, given the right investments, achieve outcomes such as rapid reductions in maternal, neonatal and young child deaths. They can also promote equity and universal health coverage as they promote resource efficiency and better access to health.

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Donors and agencies can work to support coherent implementation of an EPHS, with coordinated inputs at regional and district level. This can also be channelled via a health pooled fund, potentially with contracting-out of service delivery in different districts to different agencies supporting district health structures.

As well as the disease-specific components, essential packages can also specify management components such as harnessing citizen engagement and financing modalities that support delivery in the country, that ensure HRH components are funded as well as drugs or supplies. They can identify what percentage of funding might come from local authorities and communities as well as the central ministry of health and donors (e.g. Somali EPHS). Health insurance mechanisms can be streamlined with essential packages following pilots of successful models (whether community, social or national systems).

IMPROVING RISK MANAGEMENT

Governments and partners should create risk-management frameworks that identify risks (fiduciary, programmatic, governance, health service risks)\(^7\) and that provide targeted support to overcome these.

Partners for service delivery in a pooled fund can be selected competitively based on their successful track record of working in the country or similar challenging environments. The introduction of extra fiduciary oversight for the state and partner implementers (10) can be helpful, with greater sharing of health data and financial accounts with all stakeholders.

Staff of international agencies should be selected on their prior experience working in challenging operating environments (COEs), and increased financial and security investments made to ensure they are appropriately trained.

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\(^7\) The Global Fund’s QUART tool is a good example of an operational risk management tool. The QUART tool produces a “heat map” that exposes areas of risk. (QUART = Qualitative risk assessment, action planning and tracking tool).

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and enabled to access remote and dangerous areas. Governments should increase support (technical, financial and security) for staff working in higher risk areas.

**COORDINATION AND MONITORING MECHANISMS**

Where governance is weak, there will often be parallel, overlapping and competing initiatives. Ministries of Health need support to increase their ability to coordinate all the inputs, and encourage partners to work within the same policy frameworks, on the same procurement and data systems and to the same set of indicators. Wherever possible, Global Health Cluster coordination should come within, and help develop capacity of Ministry of Health leadership and coordination.

Development agencies need to collaborate around unified provincial and district delivery models, ideally with pooled funds (11) and resources, and the adoption of commonly agreed, ideally national, indicators for measuring impact. Flexibility in allocating resources within disease-specific programmes allows different agencies to support common delivery and monitoring mechanisms.

For example in Liberia, agencies worked around a commonly-developed National Health Plan, with funding from a pooled fund, to enable the Ministry of Health (MoH) to provide policy leadership, better manage money and have the necessary institutional capacity to guide partners around common deliverables. This contributed to a doubling of health facilities able to deliver a package of health services in the two years between 2008 and 2010 (12).

Donors should increasingly collaborate together in building up key national subsectors like M&E or PSM, and enable the MoH to channel combined inputs of different donors

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8 For example in DRC, donors have combined investments of 16m USD to support national roll out of DHIS2 software for the national health information system.
around common national reporting and accountability mechanisms.

**WHAT CHANGES IN EMERGENCIES?**

By their very nature, countries with a high index of fragility are likely to be experiencing conflict or recurrent natural hazards, which the authorities (with limited capacity) cannot manage alone. They may be confronted with different emergencies simultaneously.

Separated humanitarian and development responses are not particularly helpful when applied to these scenarios, with a *linking relief and rehabilitation to development* (LRRD) approach more appropriate\(^9\). While some degree of emergency response is likely to be needed in many parts of a state experiencing fragility at any time, the need to build capacity for the national and regional systems to be able to both prevent and respond to these emergencies cannot be underestimated, nor can the need for long-term predictable funds from donors\(^1\).\(^1\)

The delayed, but finally generous, international response to the Ebola virus epidemic in three West African countries in 2014 should as much target the development of health systems as the emergency disease-control measures so that these countries are able to pre-empt future epidemics.

Government and agencies together should aim to ‘**build back better**’ after disasters\(^1\), building safer infrastructure, creating resilience to public health hazards and future disasters, and provide equitable and affordable services to all\(^1\). Recovery planning may be informed by a *Post*.

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\(^9\) In line with the Good Humanitarian Donorship (GHD) initiative of 2003.

\(^1\) The catch phrase was coined during the response to the 2004 Indian Ocean Tsunami. The recovery period following a disaster can also provide opportunity for the transformation of political relations within a country or, as happened in Myanmar after Cyclone Nargis, when trust was built up between the Myanmar government and the international community.
Disaster Needs Assessment (PDNA), that includes assessment of damage and loss and maps out plans to rebuild in all sectors, including health (14).

Agencies supporting frontline delivery of health care need to build capacity for disaster risk reduction and disaster response, whether from human-made violence or natural hazards like drought, floods or epidemics.

Personnel should be trained in contingencies, with emergency stocks of supplies and medicines, alternative financing modalities planned, and hospitals and health centres constructed that are resistant to multiple threats.

Health facilities become much more sustainable and able to respond in emergencies if there is strong citizen empowerment and involvement in health facility management and some degree of community ownership, which will in turn help the health system to better meet health targets and reduce mortality.

KEY REFERENCES


