

High-Level Forum on the Health MDGs

**ACHIEVING THE HEALTH MILLENNIUM DEVELOPMENT GOALS
IN FRAGILE STATES**

Abuja December 2004

Summary

The success of the Millennium Declaration and Millennium Development Goals (MDGs) requires major improvements in health systems and health outcomes across the developing world. Achieving the Health MDGs is a complex and challenging task. Rapid progress is needed if these goals are to be achieved by 2015. This is a demanding agenda even in stable, well-governed low income countries. But the situation is particularly difficult in a large group of low-income countries with poor and deteriorating economic and social conditions, weak governance and ineffective government-donor relationships.

It is not easy for development agencies to engage with these 'fragile states'. Consequently, donors often choose to bypass state systems when providing development assistance to the health sector. And many donors choose not to operate in fragile states at all - re-directing their aid to more stable low-income countries instead.

But lack of progress on health in fragile states is undermining global progress on the health - and non-health - Millennium Development Goals. Fragile states account for a disproportionate number of the poor worldwide: a third of maternal deaths and nearly half of under-five deaths in developing countries occur in fragile states. It is essential that we find more effective ways of achieving the health MDGs in these countries.

Important challenges that need to be addressed include:

Promoting aid effectiveness in fragile states

- Development assistance is most effective when it is *harmonized* (through use of common procedures for all donors) and *aligned* (by supporting countries' own priorities and delivery systems). But government systems and priority-setting is weak in fragile states and donors often develop their own parallel systems - further undermining weak state capacity. In humanitarian crises and post-conflict situations, assistance is usually provided through individual projects - resulting in a large number of aid actors and delivery systems which often persist beyond the emergency period.
- There is much that can be done to improve harmonization and alignment, even in emergency situations. Development agencies can use existing resource mobilization and planning tools such as common action plans, trust funds and common assistance frameworks to minimize transaction costs in-country. New approaches such as 'shadow' alignment with government systems and priorities (for example, basing donors' systems on local administrative boundaries or using local planning and budgeting cycles) can help to support eventual alignment with state systems as governance and stability improve.

Improving health service delivery

- In all types of fragile states, it is important to develop a longer-term vision of a pro-poor health system, even when donor and government efforts are focused on short-term measures that will keep the health system going. These short-term measures are likely to include actions adapted to specific circumstances of fragile states, such as creating “Islands of Dependability” that will help retain health workers and maintain trust in the health system. Recent work in early post-conflict situations has demonstrated the value of developing a strategic framework and policies for the health sector as early as possible. The tools emerging from the harmonization and alignment agenda could also be adapted to support health planning in fragile states with weak government capacity.
- Decisions also need to be made about how services should be delivered and who should provide them. One challenge is how to integrate vertical, disease-specific approaches with horizontal, system-wide approaches - and how this mix should change over time. A further challenge is how to make best use of all service providers - state and non-state - within the health system. Generating demand for services in environments where health sector has traditionally performed very poorly is another key issue.
- Finally, health service delivery requires health workers, and the resources to train, equip and pay them. Fragile states face specific difficulties in financing health systems and retaining trained health workers. Even where there is political will, significant donor assistance is needed to rebuild systems. Development of the health sector is likely to be more expensive in fragile states than in other low-income countries (for example, due to poor infrastructure, insecurity or small-scale operations). Donors also need to explore how to manage the transition from conflict to post-conflict financing of health - to avoid a gap in support.

Further work is needed in a number of areas to reduce the costs and uncertainty of working in fragile states, including:

- Finding better tools for harmonization and alignment in fragile states;
- Further research into health policy formulation - including developing tool-kits for post-conflict health planning and the identification and tackling of bottlenecks;
- A better evidence base for models of health-care delivery, and their applicability in different types of fragile states;
- More work on the best mix of service providers and the trade-offs between building Ministry of Health capacity and contracting out to non-state providers;
- More evidence on how to re-build the health workforce in fragile states;
- More evidence on how best to finance the health sector in fragile states - including how to use resources (whether government or donor) more efficiently;

- Convincing donors to increase investment in health systems in fragile states, by tackling skepticism about the impact of programmes and identifying ways of reducing the costs of engaging in these countries.

1. Introduction

In 2000, the UN Millennium Declaration was signed by 189 countries, and resulted in eight Millennium Development Goals (MDGs) which together form a mutually reinforcing framework for human development. Three of the Goals are directly related to health: reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases (see Box 1).

Box 1: Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Evidence indicates that if trends observed during the 1990s continue, the health MDGs will not be reached by the target date of 2015, even though affordable, effective interventions are available to address priority health issues, as well as increasing assistance for specific diseases.¹ Major new investments, and a renewed effort towards the MDGs, are therefore required.

One significant challenge is that health systems are too fragile and fragmented to deliver appropriate health services.² A second is the limited amount of funding available.

A third concern, which is the focus of this paper, is that the MDGs will be very difficult to achieve in a particular set of low-income countries characterized by poor and often deteriorating economic and social conditions, weak governance and low levels of trust between aid donors and recipient governments.

These countries are referred to as “fragile states” in this document. There are different ways, and different names under which ‘fragile states’ are being classified (see Annex 1). They can be broadly divided into four groups: those in conflict; those making the transition from conflict to peace; those experience prolonged political crisis; and those states which are relatively stable but which have chronically poor capacity and governance.

Predictions show that if current rates of improvement stay the same in fragile states, the global MDG targets cannot be met, regardless of how much progress is made in other developing countries.³ Fragile states are home to about 15% of the world’s population and contain approximately:

- a third of those living in absolute poverty in the world;
- a third of maternal deaths each year in developing countries;

nearly half of the children dying before their fifth birthday each year in developing countries;

a third of those living with HIV/AIDS in developing countries;

on average, one in three people living in fragile states is undernourished; this proportion is twice as high as in other developing countries.

Eight countries are consistently mentioned in various categorizations of fragile states⁴ : Afghanistan, Angola, Democratic Republic of Congo, Myanmar, Niger, Nigeria, Somalia and Sudan. Together, these eight countries hold 58% of people living on less than a dollar a day, and 54% of total under-five deaths, out a group of 46 'fragile states' as defined by World Bank.

The very nature of fragile states makes them difficult to engage with. They have a range of characteristics: state collapse (Somalia), loss of territorial control (Nepal, Sudan, Pakistan), low administration capacity (Guinea-Bissau), political instability (Central African Republic), neo-patrimonial politics (Indonesia under Suharto), conflict-affected (Angola, Sri Lanka, Afghanistan) and repressive politics (Myanmar).⁵

Poor governance and low levels of trust between aid donors and recipient governments makes development cooperation difficult. Government departments, such as the Ministry of Health, often function poorly in terms of staff morale, management capability and policy formulation. There is a tendency for donor governments to avoid partnership with the recipient state and channel funds through non-state providers. This may undermine the (long-term) objective of supporting the state to improve its capacity to provide health services.

In states where governance is a key challenge, and where bilateral engagement is low, the UN often assumes an important coordination role. For example, in Myanmar, UN agencies, NGOs, and the Myanmar National HIV/AIDS Program collaborated in preparing and implementing a Joint Program for HIV/AIDS for 2003-2005, with UNAIDS taking up a coordination role. The government, which had been denying the seriousness of HIV/AIDS, changed its position in the process and now has significant ownership of the problem and the program. Experience suggests that at the program level, it is possible to build cooperative relations to address important social issues that overcome domestic political divides and antagonisms in the relations between the donors and government⁶

Personal security is another challenge to working in many fragile states. UN and non-governmental agencies have had to withdraw from high-risk environments due to security concerns for their staff. Within a country, security concerns effect where health services can be delivered, thus impacting coverage.

The orthodoxy that aid is most effective in well-governed countries⁷ has caused the international community to neglect fragile states in the past decade. However, the drive to achieve the MDGs as an expression of pro-poor policies; the recognition of the failure of sanctions and conditionality; the post 9/11 concern with security; and the fear of infectious diseases spreading from fragile states to the developed world, have together sparked renewed interest in approaches to re-engagement. Two topics are of increasing interest within the health sector – how to improve aid coordination and how to scale-up delivery of effective and quality services. These are both subjects of concern, but there is limited conclusive or in-depth research on either.

This document will outline the key issues and challenges surrounding these two topics, and outline areas for further work. It will not address the issues around the categorization of fragile states, nor volumes and allocation of aid between and within fragile states.

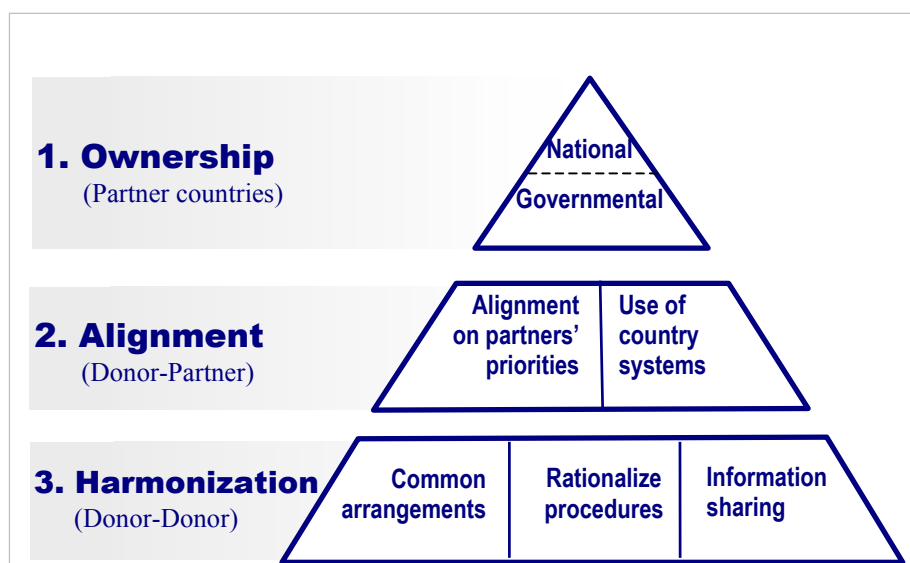
2. Issues & Challenges to attaining the MDGs in fragile states

Aid effectiveness: harmonization and alignment issues

Harmonization and alignment

The move towards greater *harmonization and alignment* of donor assistance has emerged out of a concern with the growing number of (sometimes duplicative) aid projects and programmes, the associated transaction costs for developing countries of having to engage with multiple partners (often giving competing advice), and a belief that developing countries should take much stronger role in decisions about how donor resources are used. The Rome commitments on alignment and harmonization (2003) (Box 2) were one of the first important expressions of donor commitment to harmonization.

Box 2: The Harmonization and Alignment Pyramid



The harmonization and alignment agenda cuts across the discussion around aid modalities and instruments, and applies to both project and programme approaches. Alignment concerns the relationship between donor governments and partner government or authorities. Harmonization concerns the relationship between different donors.

Within alignment, a distinction is made between alignment of donors with partner priorities and alignment with their national systems. Partner priorities might be reflected in national strategy documents or frameworks. Alignment with systems would include the timing of the national planning processes and the budget cycle, using the same accounting systems, or recognizing and using national administrative channels and boundaries.

Harmonization between donors concerns their relationship with each other. These include classic donor coordination activities like sharing information about activities and plans, as well as rationalizing procedures, such as reducing or streamlining the number of conditions placed on a recipient, or simplifying procurement procedures. Harmonization also includes developing common, shared arrangements between, such as using the same reporting or monitoring and evaluation framework or delegating a whole programme to be managed by another donor (silent partnership).

The relevance of harmonization and alignment to fragile states

The harmonization and alignment agenda is still in its inception, even in better performing developing countries. Discussion remains largely focused at headquarters within aid departments. The impact on the ground, and particularly in fragile states has been very limited to date.

Even so, emerging work suggests harmonization and alignment is particularly relevant in fragile states.⁸ In these environments, where weak state systems are not trusted, donors may avoid state partnership and establish their own priorities, in the process setting-up parallel systems and avoiding (albeit fragile) state mechanisms. This approach may be taken because of donor concerns about the abuse of human rights or international humanitarian law. However, it can further weaken the state and undermine processes through which citizens hold government to account for welfare provision and protection.

In these contexts, there is often a fragmented and complex field of stakeholders. This is particularly the case in humanitarian crises and 'post'-conflict environments, where the projectized nature of the work can result in a large number of aid actors who tend to operate outside state modalities. This becomes problematic when multiple modalities and actors extend beyond the post-emergency period.

When partner countries are not able or willing to assume leadership in the management of development assistance, it is important that donors fill this gap in a coordinated way. In

parallel, donors should seek to build capacity in partner countries to manage donors. Bilateral donors may also pursue a different type of engagement, through intermediary bodies which act as “trustees” on behalf of the government. Such bodies can include the UN, either through integrated, multi-agency entity or a single agency.

There is a large range of existing aid tools that are being applied in the fragile state environments (see Annex 2). These include pre-existing resource mobilizing and planning tools such as the UN’s Common Humanitarian Action Plan (CHAP) and Consolidated Appeals Process (CAP), the United Nations Development Assistance Framework (UNDAF) and the Poverty Reduction Strategy (PRS) process. More recent introductions also include the Transitional Results Matrix (TRM), which is being piloted in Liberia, Central African Republic and Timor Leste; results of the pilot are due to be published in May 2005. Trust funds have also been used to support the health sector in Timor Leste, Afghanistan and some African countries⁹. The Global Fund for HIV/AIDS, TB and Malaria is also active in many fragile states, and is using new country coordination mechanisms to distribute money; problems with overwhelming and undermining government capacity have been reported.¹⁰

The relationship between all these different tools and financing instruments varies from country to country, and highlights the importance of the harmonization and alignment agenda.

The importance of harmonization and alignment in fragile states for health

- There is general consensus that improving health outcomes is the responsibility of the state and requires effective government systems. The alignment agenda has building state capacity at its heart. Harmonization is also critical as there are typically a large number of donors active in the health sector in fragile states, health is a popular sector to fund, and funding is primarily focused on projects.

There are a number of emerging conclusions on the importance of harmonization and alignment for the health sector:

Donor behaviour needs to grapple with the challenge of drawing together a range of partner actors to ‘harmonize to align’ (i.e. to develop a more coordinated response to the health sector which is aligned around country priorities). There remains the tension around whether this is best undertaken at sectoral level or through more comprehensive, cross sectoral approaches which also address the broad determinants of health (such as education and the environment). There can also be a tension if country priorities are seen to be inappropriate and ineffective (e.g., certain out-of-date medicines are promoted, or current health policies are not regarded as pro-poor).

For alignment specifically, the emerging lessons and recommendations focus on the importance of addressing specific health priorities (such as reducing malaria rates or increasing access to immunization) while at the same time strengthening the health system. Even where it is not possible or desirable to support the government's priorities, it is potentially possible to carefully 'shadow' align with systems, such as administrative boundaries or the budget and planning cycle at local level (Annex 3). For example, humanitarian agencies can use existing geographical boundaries to define their health projects. This approach could be taken in situations where issues around legitimizing a regime or authority are a serious concern; where there is a lack of trust that donor resources will be well used; or where existing health priorities are thought to be inappropriate. However, shadow alignment needs to be based on a detailed review of existing formal and informal arrangements. This review should inform decisions about, for example, which components of health provision donors should attempt to align to (in a harmonized manner). Key elements determining the success of such an approach include a move to streamlined financing arrangements, and a focus on supporting partners to develop an aid management capacity in the health sector. In-country monitoring of donor behaviour in the health sector might include monitoring different health initiatives and ensuring that they are complementary and provide appropriate coverage.

For harmonization, one important implication for donors is that their engagement in the health sector is likely to be more effective if it is rationalized, with only one or two donors focusing on that sector and perhaps doing so exclusively. For those who do engage, health programming needs to include aligning donor practices and procedures across the range of the 'planning cycle'. This includes analytical and diagnostic work on the health system, better health policy formulation and health financing, communication with the Ministries of Health and Finance, complementary implementation of activities and monitoring, evaluation and audit.

Fragile states will continue to be recipients of humanitarian assistance, especially where engagement with particularly isolationist governments remains difficult, for example Myanmar or Zimbabwe. There remain significant challenges in understanding both the distinctiveness of approach for humanitarian action, and in identifying shared areas of concern between humanitarian and development assistance.¹¹

The recent Good Humanitarian Donorship (GHD) initiative aims to harmonize and simplify reporting requirements and other management demands, as well as harmonizing policy approaches at field level; it is a timely initiative in relation to this agenda. Humanitarian donor departments should look to both learn lessons from the Rome Commitments, as well as share the GHD principles and good practice with development counterparts in order to formulate a more effective model for 'transitional' assistance.

Issues Around Health Service Delivery

Introduction

The three directly health-related MDGs -- reducing child mortality, improving maternal mortality and combating HIV/Aids, malaria and other diseases -- can be directly affected by improved health service delivery and more effective public health interventions. The other five MDGs have close ties to health in that improved health outcomes both influence and are influenced by, the achievement of other Goals.

Recent work by the Commission on Macroeconomics and Health (CMH) has shown the potential for health services to improve health and reduce poverty. The CMH argued that this could be achieved if resources were found to implement a package of 49 known priority health interventions, based on burden of disease, technical efficacy, feasibility of delivery, cost-effectiveness and demand characteristics.¹² The majority of these health interventions can be delivered by relatively low-level health facilities, such as small hospitals, health centres, health posts and outreach activities. The CMH warned, however, that in addition to obtaining sufficient resources, much more work needs to be done to overcome the many constraints health systems face to scale up these health interventions. A new Taskforce recently repeated this call in light of current concerns regarding the achievement of the health MDGs, highlighting the need to invest much more in health systems research.¹³ Community-level interventions, such as the promotion of exclusive breastfeeding, are also important - even more so in environments of limited resources and ineffective health systems.

These general concerns are obviously compounded by the difficult environments typical of fragile states. Not only do existing health systems tend to focus on the better off rather than the poor (for example, by concentrating services in urban centres), but invariably they have been subjected to prolonged periods of outright neglect and decay. Figure 1 aims to capture the influence of this neglect on various health system components. The figure highlights what may occur during conflict, but many of the same features are also encountered post-conflict countries and those with weak governance.

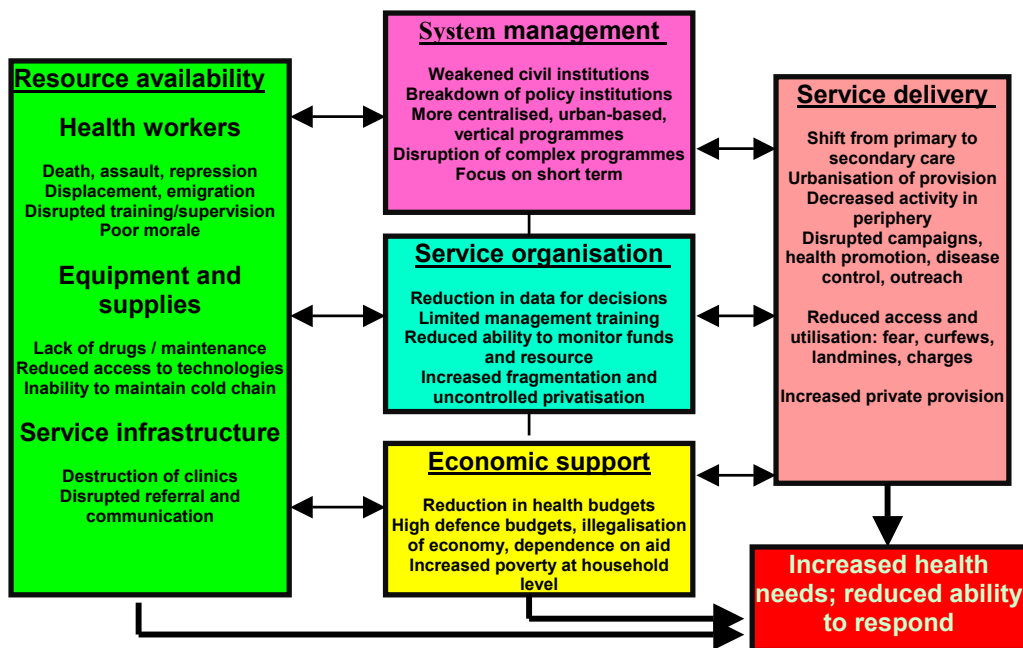


Figure 1 -- Effects of chronic conflict on health system components

The following sections set out key issues that may help in addressing the health MDGs in fragile states. It is argued that more attention can and should be paid to appropriate health policy formulation relevant to these environments. This is followed by descriptions of health care delivery issues (models and providers) and the need for improved human and financial resources.

Health Policy Formulation

A recent trend in early post-conflict situations, led by the World Bank, has been to put much more emphasis on the creation of a strategic framework and policies for the health sector. This approach shown benefits in Kosovo, Timor Leste and Afghanistan, despite shortcomings, such as the lack of a broad consultative process.¹⁴ These rapidly changing, dynamic environments require policies to address the most urgent health needs and to provide guidance to those who control increased aid flows, while taking into account the need to rebuild public health and health delivery systems in the longer term. Typically, such policy is formulated by a newly emerging Ministry of Health, with some assistance from external experts.

This model of health policy formulation may be applied in other fragile states, where a robust policy environment is lacking.¹⁵ For example, in chronic conflicts it is rare to find attempts to define an overarching health policy to give guidance on what health interventions should be delivered and by what mix of vertical and/or horizontal delivery. Activities are typically developed by international NGOs and UN agencies in an ad-hoc way, based on what they perceive as needs, coupled with their own capacity. Health authorities in conflict zones are usually weak and lack the capacity and often the legitimacy

to set policy. UN agencies could play more of a role, but lack the mandate and often times the capacity to do so. Further work is needed to explore how far it is possible to develop a programmatic approach in such environments.

In other environments, such as those characterized by stable but weak governance, lack of government capacity and political will may affect strategic policy-making. In such cases, the tools emerging from the harmonization and alignment agenda may be useful in stimulating policy formulation. A tool-kit on post-conflict health planning has been produced that could be adapted to other fragile environments.¹⁶ It will not be possible to impose a policy on all stakeholders, but it is reasonable to assume that a technically sound policy, well communicated by a credible agency, will be taken seriously by the majority of key players.

In all types of fragile states, a longer-term vision of a pro-poor health system is important while taking short-term measures. In humanitarian and development assistance, “inequality” has different meanings and implications. Most policy and decision-makers would subscribe to the principle that equality in access to basic health care should be the long-term goal. Conversely, in humanitarian assistance, the right to equal access to health care is elusive. Realization of this right is constrained by funding, security and logistic constraints. There is a funding threshold below which no effective services can be offered. The very size of a country and the difficult terrain are other constraints to the expansion of services. Populations stuck in inaccessible areas may have no dependable access to health services except those that are provided through local assets (usually insufficient and of poor quality). Limitations on funding and access mean that service providers have difficult choices. Should they concentrate on the provision of essential services of quality to those who can be reached, or should they stretch their capacity to get to those who are hard to access, perhaps at the expense of service quality and range? The goal should never be to equalize misery and suffering: it is preferable to save lives quickly rather than wait for more resources and opportunities to meet the service needs of the entire population at risk. In most circumstances, the health MDGs can provide a broad framework to inform the development of health policy.

Health information systems in fragile states are often very weak, undermining the basis for decision-making. For example, the development of a basic package is more complicated with an uncertain morbidity profile. UN and NGO systems can be important sources of data, and where possible should be (shadow) aligned with government information services. In humanitarian settings, the CAP and the Common Humanitarian Action Plan (CHAP) have potential for strategic coordination and information sharing, but often do not include all stakeholders. They are, however, undergoing improvements to their needs assessments and planning processes. There are no good information links yet between CAPs, transitional results frameworks, interim Poverty Reduction Strategy Papers (I-

PRSPs), and UNDAF. A mapping out of these different tools and their associated information sources and databases would help to clarify where complementarity exists.

In immediate post-conflict environments, the health sector may be used as a tool to promote peace-building, or as a way to engage with communities. For example, health could be a way to initiate engagement around a relatively 'neutral' issue (such as the need for an immunization drive), to bring opposing parties around the table under a health banner, or to stimulate community development. Occasionally, health policy is particularly influenced by fear of a certain disease that may affect citizens in neighbouring or distant countries, such as HIV/AIDS, Ebola, SARS and polio.

Finally, the goal of health policies in these settings may be more focused on preventing further deterioration rather than on achieving improvements. Examples are attempts to prop-up health institutions to prevent them from further degradation, with the argument that keeping them afloat during a difficult time may be cheaper than rebuilding them later. Another example is the prevention of 'catastrophic health expenditures' which may heavily affect people's assets and livelihoods. Yet another example is support to 'islands of dependability', e.g. a specific hospital or group of clinics which offer ongoing quality services. These may not immediately be extendable or replicable, but their continuation will be crucial in maintaining trust in the health service and can provide crucial input to later efforts to rebuild the service.

Summarizing, there is scope to improve the policy making process for health services delivery in various difficult settings. More work, however, needs to be done to identify current bottlenecks in terms of agency willingness and capacity to formulate health policy and ways to overcome these constraints. More work is also needed on how to adapt different approaches to different "types" of fragile states. For example, creating "islands of dependability" may be most appropriate in conflict or post-conflict countries; contracting of Non-Government Service Providers in transition states, and shadow alignment in countries experiencing prolonged political crises. Exploring these approaches and combinations of approaches in more detail is an important subject of further exploration.

Health care delivery systems and providers: a health systems approach

The attainment of the MDGs is an enormous task, requiring not only adequate funds, but also the right policies (the 'what'), as well as effective implementation, appropriate health systems, increased demand and above all, enough health staff (the 'how').¹⁷ There is growing consensus that a health systems approach is the best way forward to achieving the MDGs.¹⁸ As some commentators have observed, "MDGs formulated in disease-specific terms must not become the excuse for failing to prioritize systemic solutions".¹⁹ Within this consensus, however, are many debates on how to best formulate a health

system. Two issues will be considered here: how should services be delivered, and who should provide the services.

For the first issue, on how services should be delivered, the debate centres on how best to integrate vertical, disease-specific approaches with more horizontal system-wide approaches. Recent work concludes that “there is scope for use of both vertical and horizontal delivery mechanisms, and that the choice of delivery mode needs to be guided by the capacity of the specific health system, and how this evolves over time.”²⁰ The practicalities of how to implement this advice requires much more analysis, particularly in the context of fragile states.

The implementation of a fully-fledged health package, as recommended by the CMH, is one possible horizontal service approach. Providing the full CMH package is difficult in most fragile states, so the alternative is a scaled down “basic package”. The current roll-out of a basic package of health services in ‘post-conflict’ Afghanistan is a useful example of this approach. This package, to be made universally available to all Afghans, addresses maternal mortality through emergency obstetric care services and family planning, child mortality through immunization, treatment of childhood diseases and micro-nutrient supplementation, and incorporates tuberculosis and malaria control, but not HIV.²¹ The formulation of this package forced health planners to think through requirements in terms of health facilities, health staff, equipment and supplies as well as other system issues.

More robust evidence is required on the usefulness of basic packages in fragile states, both from the supply and demand side. Implementation strategies, such as how to develop a basic package, and how to roll it out (and other sequencing issues) need to be further investigated. Their relationship to other health components, such as hospitals, needs more work. Recent experience has shown that, at least in recent post-conflict environments, hospitals are often neglected.

The second question concerns *who* should provide health services. Most developing countries rely on the state. Some argue that ‘contracting out’ can help reduce some the inefficiencies often associated with state provision of health care. Under such a model, the state continues to set policies and regulates provision, while purchasing health services via contracts with non-state providers (NSPs), such as NGOs. This approach has been used in Cambodia, where research shows that districts using ‘contracts’ consistently outperform control districts on a range of indicators including: health service coverage, increase in the use of reproductive health services, immunization rates, decline in time lost due to illness. Moreover, these districts provide more than proportionate benefits to the poorⁱ.

ⁱ “Achieving the twin objectives of Efficiency and Equity: Contracting Health Services in Cambodia”. Contracting-out in which contractors have full responsibility for the delivery of specified services; directly employ their staff and have full management control, as compared to contracting in where contractors provide only management support to civil service health staff. (http://www.adb.org/Documents/EDRC/Policy_Briefs/PB006.pdf)

However, there are many constraints to the use of contracts. These include the lack of government capacity in many countries to issue, design and monitor contracts; lack of technical and administrative capacity among providers; lack of competition for contracts; and high transaction costs.²² Contracting out health services may also have far-reaching consequences for staff retention (in the public sector) and continued education. More work is therefore needed to define the pre-requisites that will have to be fulfilled before a national non-state entity or international agency can take on the contracting role, particularly in fragile states where government capacity is weak and transparency is an issue. Emerging evidence from other countries which are experimenting with large-scale contracting out of services, including Afghanistan, will be important in this regard.

Generating demand for health services is a critical aspect of rebuilding the health sector. This is particularly so in fragile states, where citizen's trust may have deteriorated due to poor access and low quality services. Community-based approaches, which seek to empower communities' demand for and control over services from local government, are crucial. Community-level interventions which address the social determinants of health are also important, such as social protection schemes. A "Community Managed Model" for primary health care has been piloted successfully through the Somali Red Crescent in Puntland, Somalia. The model involves local people in the running and resourcing (through community contributions) of 12 primary health clinics. A recent evaluation found that the project 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.ⁱⁱ

Human and Financial Resources

Health service delivery needs two key resources: health workers, and funds to pay health staff, purchase equipment and supplies, and to build and maintain health infrastructure. How these resources are used -- in particular in creating services that are accessible (in both geographical and financial terms) and of high quality - is equally important.

There are many issues related to health workers in low-income countries. All these issues are also pertinent to fragile states. Since these general issues are the subject of other work related to the health MDGs they will not be dealt with here. There are, however, a number of issues specific to fragile states that should be mentioned. These include: the problem of much project-based training without accreditation; the forced migration and voluntary emigration of health workers; and unregulated use of incentives by various agencies. There are also more positive aspects, such as the numerous capacity-building programs that are often implemented during times of crises.

ⁱⁱ Joint Somalia Red Crescent Society / International Federation of Red Cross and Red Crescent Societies / World Bank Somalia, Evaluation, July 2004.

In a number of fragile states, governments lack the will rather than the capacity to pay for service delivery. In most, however, they do not have the requisite resources due to their poor economies; even if an adequate percentage of the national budget were spent on health, a substantial health financing gap would continue to exist for the delivery of a very basic package of health services to the majority of the population. External donors are reluctant to fill the gap for a variety of reasons, including the current orthodoxy to support only 'good governance' countries, the risk of embezzlement and the sheer lack of trust that money spent on health in these environments will have measurable positive effects. The final resort -- to start relying on user fees collected from patients to fill the gap -- is counter-productive. Time and again it has been shown that the financial gain is marginal, that resources are not used efficiently and that the poor are disproportionately affected by.²³

It has been estimated that a five-fold increase in donor spending on health is needed to meet the health MDGs.²⁴ In this regard, it is important to acknowledge that working in fragile states may be more expensive. Insecurity, raised transport costs due to poor infrastructure, use of non-national staff, staff incentives, small-scale operations and high transaction costs may all increase the price in these environments. Discussion on financing should also recognize that more funding is needed for health systems development, which is a necessary but not sufficient factor to meet the MDGs. Current funding is inadequate, and often inadequately balanced between systems strengthening and more vertical approaches.

Budget support is uncommon in fragile states given the poor levels of trust between donors and governments. There is, however, some experience of using highly-earmarked budget support, either for accredited service providers or to generate demand for services (e.g. vouchers for free access to specific services). Both approaches require strong accountability mechanisms, for example by having an independent financial management entity that handles resources on behalf of the State and donors. One example of this approach is the health budget support provided by Swiss Development Cooperation in Mozambique during the war.

Another issue that needs to be addressed in fragile states is funding during the transition from conflict to post-conflict. Post-conflict relapses into renewed violence account for around half of all global civil wars. There is increasing evidence that improved interventions in post-conflict situations may reduce this risk. Higher aid for post-conflict situations looks to be a good use of international public resources as long as it is properly timed.²⁵ Current aid mechanisms typically leave a gap between the end of humanitarian funding and the decision to begin development funding, with the result that there is a period where resources 'dry up'. New mechanisms are being explored by various bi- and multi-lateral donors, such as Trust Funds used in Afghanistan and Timor Leste. However these are still exploratory, and initial reports reveal that some gaps remain.²⁶

3. Areas of Further Work

In order to relax the constraints to working in fragile states and increase the opportunities to meet the health MDGs, the following areas of further work are suggested.

Improve Donor Behaviour (Harmonization and Alignment)

Donor behaviour needs to grapple with the challenge of drawing together a range of partner to 'harmonize to align' in the health sector. In terms of alignment between donors and partner governments, the emerging lesson is to focus on government priorities. Where it is not possible or desirable to support the authorities' priorities, it is potentially possible to carefully 'shadow' align with systems, such as administrative boundaries or the budget and planning cycle at local level. More work is needed on how to operationalize this principle in practice.

Planning across sectors may also be helpful via the use of transitional matrices. More work needs to be done on understanding the complexity and complementarity of existing aid mechanisms (CAPS, CHAPS, I-PRSPs) and how they need to adapt to support better harmonization and alignment. This also applies to supporting activities such as rapid assessments, priority setting, and joint action plans.

Further work is needed on identifying shared areas of concern for humanitarian and development assistance, and specifically how far it is possible to develop a programmatic approach in the various fragile state environments.

Health Service Delivery

Health policy formulation: The evidence-base is very weak regarding ways to organize, deliver and pay for effective and equitable health services in resource-constrained settings.²⁷ Further research is required on how to strengthen the policy environment and support policy-making processes. More work also needs to be done to identify and overcome bottlenecks in terms of agency willingness and capacity to formulate health policy. Special attention will need to be paid to the role of the UN. The policy content will be different in different settings, but in almost all contexts, the idea of 'working towards attainment of the MDGs' could provide an overarching framework.

The concept of 'islands of dependability' should be further explored, and implications for implementation studied. Post-conflict toolkits for health planning may also be useful and could be adapted for fragile states in general. UN and NGO data systems can be important sources of data. Mapping out how they are complementary would be helpful; the possibility for (shadow) alignment with government information services could be explored in some situations.

Health service delivery – what and who: Better evidence is needed on which model or combinations of models for health care delivery (basic packages, vertical approaches, islands of dependability, the role of hospitals) works better in environments of poor governance and limited resources.

Basic packages are promising, but more robust evidence is required on their usefulness in fragile states, both from the supply and demand side. Implementation strategies on how to roll out the basic package and how to relate it to other health components, such as hospitals and 'non-essential' health interventions, need to be further explored.

More work is needed on the best mix of health providers, including how NSPs can be used for service delivery, and what is the trade-off with building MoH capacity (including strengthening public health, which needs to be done by through state channels). More work is also needed to define the pre-requisites that will have to be in place before a national non-state entity or international agency can take on a contracting role.

Human and Financial Resources: Evidence is required on how to (re)-build the health workforce in fragile states. Programs such as project-based capacity building and training without accreditation should be evaluated, as well as the unregulated use of incentives by various agencies.

Health financing issues need to be better thought through. More consideration of how to meet the health financing gap, and how to use resources more efficiently is needed. Evidence should be collated on how governments can generate and sustain financing for their countries' health facilities. Donor mechanisms, such as Trust Funds, CAPS, TRMs, etc. should be submitted to in-depth evaluation. The cost of basic packages should be better assessed, as should mechanisms to finance them. Finally, the role of cost recovery and user fees should be rethought in fragile-state settings and replaced by more pro-poor alternatives.

Convincing donors: Increased and sustained external funding to provide health services in fragile states will be an absolute prerequisite to address the MDGs in these countries. Current skepticism that money vested in fragile states is wasted will need to be overcome by providing evidence to the contrary. The very nature of fragile states make sector-wide evaluations a difficult task. Due attention needs to be given to this task, and novel ways developed to circumvent current practical and methodological constraints to good quality evaluative work.

ANNEX 1 - MULTIPLE APPROACHES TO DEFINING “FRAGILE STATES”

There are many classifications of fragile states by various actors. They tend to fall into one of three categories: fragile states, poor performing countries and difficult partnerships.²⁸ Each of these approaches has its own rationale which is based on the mandate of the agency doing the classification. Attempts to define the nature of fragile states generally draw on subjective indicators/material. Hence it is hard to pinpoint a single set of countries or set of concerns, and the categorizations are highly dependent on the nature of the relationship with the donor community.

Fragile States: these approaches encompass fragile, failed, failing and crises states, and are based on a continuum approach. Assessments are broadly based on a state’s strength regarding issues of capability, sovereignty and levels of conflict. USAID’s 2004 Fragile States Strategy is an example of this approach. Others include the European Council, the Crisis States Programme and the State Failure Task Force.

Poorly Performing Countries: the international financial institutions focus their approach to difficult environments around how well a country performs in terms of development outcomes, taking into account the quality of governance and policy choices. The World Bank’s ‘Low Income Countries Under Stress’ (LICUS) initiative is the best-known; the Asian Development Bank, UNDP and Ausaid have also taken the ‘poor performing’ countries approach.

Difficult Aid Partnerships: in this approach, the emphasis is placed on the poor relationships between donors and recipient states due to a combination of: a) lack of political interest in poverty reduction, and b) weak state and non-state institutional capacity to implement policy. The OECD’s Development Assistance Committee (DAC) was a pioneer of this approach, focusing on the importance of whether and how donor-recipient partnership can function effectively.

These approaches are all evolving, and to some extent converging, over time. For example, OECD and the World Bank are now using the terms “fragile states” and “difficult partnerships” interchangeably.

ANNEX 2 – ILLUSTRATIVE EXAMPLE OF CURRENT AID MECHANISMS

Name of instrument	Agent responsible for process	Source	Purpose of process (in theory)
Humanitarian response tools			
Common Humanitarian Action Plan (CHAP)	United Nations Humanitarian Coordinator/ Inter-Agency Standing Committee Country Team	United Nations	Planning by UN agencies for humanitarian response to a crisis or emergency
Consolidated Appeals Process (CAP)	UN agencies	UN agencies	A set of programs and projects managed by the UN agencies for financing
UN managed-TF/ direct funding of agencies	United Nations/ multi-donor	United Nations	Financing mechanisms to channel donor assistance to UN agencies either directly or through an intermediate trust fund, in emergency situations
Assessment tools			
Joint Needs Assessment (JNA)	Joint donor or donor-government	Multilateral development banks- UN	To assess the “needs” of the country as prelude to donor financing of post-conflict settlement
Common Country Assessment (CCA)	UN agencies	UN agencies	To assess the country’s development needs as a basis for UN agency planning
Strategy/ planning processes			
Poverty Reduction Strategy process (PRS)	Government	World Bank	Preparation, adoption and implementation of strategy owned by government around which donors are aligned
Transitional Results Matrix (TRM)	Government and/or other actors including political, military and economic	World Bank	Preparation of strategy around which political, military and aid actors are aligned.
Country Assistance Strategy (CAS)	World Bank	World Bank	Internal planning by World Bank country team for support to the government’s policies and programs
UN Development Assistance Framework (UNDAF)	UN agencies	UN agencies	A framework for assistance to the Government’s development programs
The national budget preparation process	Government	Government	Preparation of strategies, policies and programs to which resources will be allocated
Partnership/ aid pledging mechanisms			
Consultative Group	Government	World Bank	A process for coordination and information sharing between actors, led by the government
Roundtable	United Nations	United Nations	A process for coordination between donors, led by the UN

Funding mechanisms			
The National Budget/ Medium Term Expenditure Framework (MTEF)	Government	Government	A set of programs and projects for financing by internal or external resources
Funding Channels			
Government Treasury system	Government	Government	A set of accounts and regulations to manage financial flows
WB- or UN-managed TF	Government	World Bank/ UN/ multi-donor	A trust fund designed to channel money to the government, subject to checks and balances
Tracking mechanisms/ systems			
Government systems (e.g. DAD in Afghanistan, Aid Management Platform in Ethiopia)	Government	Can be donor-supported	Systems designed to track all external resources flowing to a country
Financial Tracking System (FTS)	OCHA	OCHA	System designed to track resources flowing through UN agencies.
Public Expenditure Reviews	Government/ World Bank	World Bank	Reviews of public expenditure effectiveness

ANNEX 3 - THE CONCEPT OF 'SHADOW' ALIGNMENT

The concept of shadow alignment is useful in situations where there is a:

- Lack of, competing or multiple systems
- Concerns about legitimizing a particular government or authority
- Serious concerns about the intentions of the authorities towards their own population
- A significant and prolonged humanitarian presence

If there is nothing to 'align to', interventions need to be 'shadow' aligned. This approach needs to start with assessing the available formal and informal policies and systems. (There is invariably more available than is often credited). These can then be built on, adapted and reformed, which is more effective than designing and introducing entirely new policies and systems, particularly in low capacity environments. Alignment can either be to systems (shadow systems alignment) or to policies (shadow policy alignment).

Shadow alignment is a state-avoiding approach but one that is 'future-proof'. It does not give an authority or government control over resources, but does use structures, institutions or systems which are parallel but compatible with existing or potential organization of the state. It aims to avoid creating a diversionary institutional legacy that can undermine or impede the development of a more accountable and legitimate future relationship between the people and their governments.

The key to shadow 'systems' alignment is to ensure system compatibility. The design of external interventions is made based on the parallel but consistent or compatible organizational structures and operational procedures. A central element of this is about providing information in a compatible format (e.g. budget years and classifications). Additional operational practice may include using the same or at least compatible:

- Administrative layers or boundaries;
- Planning and budgeting cycles;
- Budget classifications;
- Accounting, procurement and audit systems;
- Staffing structures and hierarchies.

In practice alignment is a question of degree. Shadow 'systems' alignment is a way of overcoming the negative effects of 'non-alignment' but is not dependent of policy alignment or handing control over resources to the authorities.

Source: Adapted (Christiansen & Coyle 2003)

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