Health Systems Strengthening in Fragile Contexts:
A Report on Good Practices & New Approaches

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Acronyms

AC	Agence d'achat
ACT	Artemisinin Combination Therapy
ADC	Accelerated Disease Control
AHDS	Afghan Health & Development Services
AIDS	Acquired Immune Deficiency Syndrome
ANDS	Afghan National Development Strategy
AQ	Amodiaquine
ART	Anti-retroviral Therapy
BHC	Basic Health Center
BOG	Basic Operating Guidelines
BPHS	Basic Package of Health Services
BSC	Balanced Score Card
CAF	Care of Afghan Families
CBPHC	Community Based Primary Health Care
CBR	Community Based Rehabilitation
CCM	Community Case Management
CCT	Conditional Cash Transfer
CDC	Centers of Disease Control (Atlanta)
CDF	Centres du Développement Familiales
CHAN	Christian Health Association of Nigeria
CHC	Community (or Comprehensive) Health Centre
CHD	County Health Department
CHDs	Child Health Days
CHP	Community Health Promoter
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CMW	Community Midwife
CSD	Compact for Service Delivery
DFID	UK's Department for International Development
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment – Short course for tuberculosis
DPO	Disabled People Organisation
DPT	Diptheria, Pertussis, Tetanus (vaccine)
DRC	Democratic Republic of the Congo
DRF	Drug Revolving Funds
EC	European Commission
ECWA	Evangelical Churches of West Africa
EJH	East Jerusalem Hospitals
EJHN	East Jerusalem Hospital Network
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EPHS (Afghanistan)	Essential Package of Hospital Services
EPHS (Somalia)	Essential Package of Health Services
EPI	Expanded Programme on Immunisation
EU	European Union
EU	European Union
FBO	Faith-Based Organisation
FMOF	Federal Ministry of Finance
FSAU	Food Security Analysis Unit
GAVI	Global Alliance for Vaccines and Immunisation
GBV	Gender Based Violence
GCMU	Grants and Contracts Management Unit
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GOSS	Government of Southern Sudan

GTZ	German Technical Cooperation
HAI	Health Alliance International
HDI	Human Development Index
HEFD	Health Economics and Financing Department
HFSN	Health and Fragile States Network
HHF	Haitian Health Foundation
HI	Handicap International
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HR	Human Resources
HSS	Health System Strengthening
IAM	International Assistance Mission
IASC	Inter-agency Standing Committee
ICAS	Central American Health Institute
IDP	Internally Displaced Person
IDU	Injecting Drug User
IFMIS	Integrated Financial Management Systems
IHE	Inter- agency Health and Nutrition Evaluation
IMCI	Integrated Management of Childhood Illness
IMPACT	Improved Management through Participatory Appraisal & Continuous Transformation
IMR	Infant Mortality Rate
IRC	International Rescue Committee
ISA	Independent Service Authority
ISS	Integrated Supportive Supervision
JSI	John Snow, Inc
KCCCP	Khartoum State Comprehensive Child Care Programme
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
KSMOH	Khartoum State Ministry of Health
LGA	Local Government Area
M&E	Monitoring and Evaluation
MAP	Measuring Access and Performance
MCH	Mother (or Maternal) and Child Health
MDGs	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MHPSS	Mental Health and Psychosocial Services
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOC	Mazar Opthalmic Center
MoF	Ministry of Finance
MoH	Ministry of Health
MoHP	Ministry of Health and Population
MOHSW	Ministry of Health and Social Welfare
MoPH	Ministry of Public Health
MSF	Médecins Sans Frontières
MSI	Marie Stopes International
MSPP	Ministère de la Santé Publique et de la Population
MUAC	Mid-Upper Arm Circumference
NCD	Non Communicable Diseases
NGO	Non-Governmental Organisation
NIBR	Norwegian Institute of Urban and Regional Research
NMCP	National Malaria Control Programme
NMEAB	National Midwifery Education and Accreditation Board
NPHCDA	National Primary Health Care Development Agency

NSEP	Needle and Syringe Exchange Programme
NT	Neonatal Tetanus
OPD	Out Patient Department
oPt	occupied Palestinian territories
PATHS	Partnerships for Transforming Health Systems (Nigeria)
PBF	Performance Based Financing
PHC	Primary Health Care
PHC/ORC	Primary Health Care Outreach Clinics
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PNG	Papua New Guinea
PPA	Performance-based Partnership Agreement
PPRHAA	Peer and Participatory Rapid Health Appraisal for Action
PRRINN	Partnership for Reviving Routine Immunisation in Northern Nigeria
PSI	Population Services International
QAR	Quality Assessment and Recognition
RBM	Roll Back Malaria
RDF	Revolving Drug Fund
REACH	Rural Expansion of Afghanistan’s Community-based Healthcare
RED	Reach Every District
REV	Reach Every Village
RH	Reproductive Health
RHG	Reproductive Health Group
RUTF	Ready-to-Use Therapeutic Food
SEDC	Safe and Effective Development in Conflict
SEEDS	State Economic Empowerment and Development Strategies
SIAs	Supplemental Immunization Activities
SMOH	State Ministry of Health
STI	Sexually Transmitted Infections
SVAs	Supplementary Vaccination Activities
TB	Tuberculosis
TBA	Traditional Birth Attendant
TISA	Transitional Islamic State of Afghanistan
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
V&A	Voice and Accountability
VAS	Vitamin A Supplementation
VCCT	Voluntary Confidential Counselling and Testing
VPD	Vaccine Preventable Disease
WB	World Bank
WFH	Weight-for-Height
WHO	World Health Organisation

1. Introduction

Strengthening health systems in fragile states is often challenging given the limited resources available, problems of governance, and the difficulties of organizing and delivering health care in these often conflict-affected settings. Despite these challenges, there has been increasing focus on strengthening health systems as fragile states (see box) have a high burden of ill health, and are currently off-track to meet the health millennium development goals (MDGs) (WorldBank 2007).

Definition of fragile states

Different terms have been used to describe those states that face particularly difficult political, social and economic conditions. They have variously been referred to as fragile states, failed states, difficult environments, difficult partnerships, and low income countries under stress. A common definition is that they are states that are unwilling and/or incapable of delivering basic services to their populations (DFID 2005). They have weak institutions and governance systems and lack effective political processes to influence the state to meet social expectations. Most experience civil conflict, and once post-conflict, suffer from high rates of relapse to conflict. Most fragile states have growing levels of extreme poverty, contrary to most low income countries. Four typologies are commonly referred to: (1) prolonged crisis or impasse; (2) post-conflict or political transition; (3) gradual improvement; or (4) deteriorating governance.

Poor health systems are considered to be a major constraint to improving health outcomes, resulting in increased efforts by the global health community to strengthen health systems. Health system strengthening (HSS) has been defined as improving the 'six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes. It requires both technical and political knowledge and action.' (WHO 2007). The six building blocks referred to are outlined below. HSS includes capacity building and other initiatives to improve the leadership, management and financing of health systems, as well as strengthening of human resources, health information and medical and drug supply systems.

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM

- Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
- A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
- A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
- A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
- **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.

Health actors in fragile states are increasingly taking a HSS approach, despite some concerns that it is not feasible or appropriate in these types of settings due to the challenges outlined above. This report is one of the first attempts to broadly outline some of these experiences to date, based on activities of the Health and Fragile States Network (HFSN) members. The information presented in this report is based on submissions contributed to the Network after two calls for submissions that were circulated in December 2008 and February 2009. It is by no means intended to be a comprehensive analysis. Rather, the aim of the report is to document and assess innovative ways to work on HSS in difficult contexts. It describes practical, field-based activities that reinforce one or more components of the health system in a sustainable way, assessing how these activities improve health care delivery systems, build institutional capacity and contribute to better governance. Most were designed to achieve at least some public health goals, including coverage, equity, efficiency, responsiveness, accessibility and sustainability. The report includes examples of service delivery models (government provision, within-government contracting, contracting-out, community-based health initiatives, work with the private sector), innovations in health financing, including performance-based incentives, as well as ways to strengthen human resources and supply chain management. It also includes some analysis of the impact of poor governance and institutional capacity building on HSS, and the interface between international agencies and weak national structures. Submissions illustrate various aspects of how to organize, deliver and fund services, and provide a snapshot of how health providers currently address key challenges in providing health care in these difficult contexts.

Overall, the report aims to shed light on whether international and local health actors can 'do' health system strengthening in various types of fragile states, where governance and institutions are weak, and resources limited. It is directed at policy-makers, donors, and field staff working to deliver health and strengthen nascent or weak health systems. Although the initial aim of the report was to include only submissions referring to externally evaluated projects or programmes, it was decided to also include submissions that describe ideas or concepts that have not yet been (fully) implemented, evaluated or tested. This was done in order to inspire new ideas and innovations for health services delivery in fragile states, which in future versions of this report could be evaluated and included as "good practice". This reflects the Health and Fragile States Network's aim to stimulate debate, documentation and research on health issues (see www.healthandfragilestates.org for more information). As such, the Network welcomes further submissions or updates to this report as well as feedback regarding experience with these or other strategies and the results obtained.

1.1 Structure of the Report

The submissions received for this report have been grouped under seven key headings which roughly correspond to the six building blocks of a health system: service delivery components, implementation and support strategies, leadership and governance, human resources, financial resources, supply chain management, and health information systems. A short introduction is included for each heading. Each of the seven topics is then further subdivided into numerous sub-topics, again with short introductions. Submissions were included under the most relevant heading, but many could have been included under other headings as they illustrate more than one aspect (for example, a single submission can describe both service delivery and human resources). All submissions have been listed by topic area, not country; for those interested in examples from a specific country, an index at the back of the report identifies the submissions by country (with hyperlinks to these sections within the report), in addition to listing the authors and agencies that contributed them.

2. Health System Strengthening: Good Practices & New Approaches

HSS initiatives in fragile states aim not only to support the achievement of the health MDGs and, where existing, specific national health targets, but they primarily seek to ensure that the delivery of national health services takes place in an equitable, accountable and sustainable manner despite the very difficult, often conflict-affected contexts. Numerous projects and initiatives have focused on HSS and health services delivery in fragile states, but descriptions of such projects are rarely available in the public domain. The foundations of a health system are crucial to determining a country's health outcomes in the long term, and especially in post-conflict countries, where both health services and health systems often need to be (re-)established, it would be invaluable to have available a toolkit of evidence-based, effective strategies and interventions that can help support decision-making. This document, although neither a toolkit nor an academic essay, seeks to inform on a broad range of subject areas relevant to HSS and service delivery in fragile states. Examples are documented of how successful systems and services were implemented in contexts where choices had to be made on implementation strategies despite little data on priority needs, and where the roles of the government, donors, NGOs, the private sector and communities in providing and monitoring health services needed to be defined. These experiences also illuminate how challenges of access, financial and human resources constraints were overcome through innovation and hard work. This document highlights the successes of these programmes, in the hope that the lessons learned can also be applied to other, similarly challenging environments.

The majority of the examples described here come from Afghanistan, probably reflecting the amount of international attention that has been directed to this country since the fall of the Taliban in 2001. There are also numerous contributions from more recent efforts in Somalia, Nigeria and Southern Sudan, as well as from Burundi, Cambodia, China, the Democratic Republic of the Congo (DRC), Guinea, Haiti, Liberia, Mozambique, Nepal, Nicaragua, Occupied Palestinian Territories (OPT), Papua New Guinea (PNG), Rwanda, Sierra Leone, Timor Leste, Yemen, and Zimbabwe. The experiences described here are, wherever possible, briefly evaluated in terms of coverage, equity, efficiency, responsiveness, accessibility and sustainability. Some of the new approaches included here have not yet been (fully) implemented and their impact cannot (yet) be determined, but it is hoped that their inclusion can contribute to the development of new ideas and innovations in the field of health systems strengthening.

Finally, in order to keep the report brief and easy to read, this document does not seek to give a detailed description of each of the projects. For those readers who would like more information on the individual examples given here, supporting documentation such as programme descriptions and evaluation reports have been posted on the Health and Fragile States Network website www.healthandfragilestates.org, along with the contact details of the individuals and/or organisations who have submitted the information used to compile this report.

2.1 Service delivery components

A health system consists of the interplay between vertical and horizontal approaches to services provision. Services are supported and implemented by actors as diverse as the government, the private sector and the communities it seeks to serve. The horizontal approach, to which HSS normally refers, generally consists of policies, strategies, systems and the infrastructure used to deliver a variety of services. As Gonzalez described it as early as 1965, it "seeks to tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as 'general health services'" (Gonzalez 1965). Mills

describes the 'vertical approach' as follows: "[It is] directed, supervised and executed, either wholly or to a great extent, by a specialised service using dedicated health workers" (Mills 2005). A number of the individual services provided through the health system are frequently associated with vertical support and policy streams, such as maternal health, child health, family planning, and control of specific infectious diseases such as HIV/AIDS and tuberculosis (TB). A number of specialised agencies, programmes, and even donors exist that target these vertical streams.

This section of the report describes how the governments of two countries have worked on putting together a number of priority interventions into a (horizontal) package of basic or essential health services, and also describes in more detail a number of (sometimes vertical) components and approaches that could be included such a package.

2.1.1 Health services packages

It is becoming increasingly popular to create and cost a basic or essential package of health services, in part because it tends to facilitate the flow of donor funds and the rapid scale-up of essential health services. In post-conflict countries such as Afghanistan, Southern Sudan, and Liberia, these often detailed plans have outlined how primary health services are to be implemented at a national level. Somalia and the DRC are currently in the process of developing such packages. These packages do not necessarily always target national services. In the Nigerian state of Ekiti, a project was piloted that used the delivery of an essential healthcare package as an entry point for a service-driven model (Enyimayew and Mckenzie 2008).

Delivery mechanisms for these service packages are described in more detail in other sections of this report. Here we focus on the development of two packages: Afghanistan and Somalia. The Basic Package of Health Services for Afghanistan (BPHS) was developed in 2002 through a collaborative process involving the Ministry of Public Health (MoPH) and key stakeholders, while the Essential Package of Health Services (EPHS) for Somalia is currently being developed, using lessons learned especially from the Afghan and Southern Sudan experiences.

A Basic Package of Health Services (Afghanistan)

At the end of 2001, after the fall of the Taliban, the Afghan public health sector was characterised by a comparatively large but dysfunctional hospital sub-sector biased towards cities, scattered remnants of vertical programmes such as malaria and TB control, and little to no presence in rural areas. The few functional health facilities were primarily supported by Non-Governmental Organisations (NGOs), while most of the population sought care in the unregulated, poor-quality private sector.

In March 2002, the Afghan Ministry of Health began a process to determine its major priorities for rebuilding the national health system, and which health services were so important for addressing the greatest health problems that they should be available to all Afghans, even those living in remote and underserved areas. It was decided to call these crucial services a Basic Package of Health Services (BPHS). The key elements to include in the BPHS were (1) those services which would have the greatest impact on the major health problems, (2) services that were cost-effective in addressing the problems faced by many people and (3) services which could be delivered to give equal access to both rural and urban populations.
The concept of the Basic Package is that all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programmes. A collaborative process was established, so that all stakeholders would have an opportunity to contribute their ideas and experience. The result of this final version of the Basic Package of Health Services is one that represents a consensus among Afghan Ministry of Health officials, NGOs, international [United Nations] UN agencies, donors, and other partners in the health sector.
The Ministry of Health expects that all NGOs and others delivering health services in Afghanistan will use this document as the basis for implementing their health programmes. The BPHS represents the official policy of the Transitional Islamic State of Afghanistan (TISA), and those delivering health services to Afghans must provide the Basic Package first before adding other services. In this way, stakeholders can be assured that the core services making up the Basic Package will be widely available, and that additional services that are not part of the Basic Package can be added as appropriate, but will not be substituted for any of the Basic Package services.

From the Introduction section of the first Afghanistan BPHS document (Transitional Islamic Government of Afghanistan 2003)

The Basic Package of Health Services (BPHS) for Afghanistan established a strategy for services delivery by defining four levels of health facilities (including the standardization of nomenclature), along with specifying the coverage area, staffing levels and the exact set of interventions and services, and the equipment and essential drug requirements for each type of facility.

Box 1 - Afghanistan's Basic Package of Health Services: Interventions and Services Provided
(Transitional Islamic Government of Afghanistan 2003)

MATERNAL AND NEWBORN HEALTH
- Antenatal Care
- Delivery Care
- Postpartum Care
- Family Planning
- Care of the Newborn

CHILD HEALTH AND IMMUNIZATION
- EPI services (routine and outreach)
- Integrated Management of Childhood Illness

PUBLIC NUTRITION
- Micronutrient supplementation
- Treatment of clinical malnutrition

COMMUNICABLE DISEASES
- Control of Tuberculosis
- Control of Malaria

MENTAL HEALTH
- Community management of mental problems
- Health facility based treatment of outpatients and inpatients

DISABILITY
- Physiotherapy integrated into Public Health Care (PHC) services
- Orthopaedic services expanded to hospital level

SUPPLY OF ESSENTIAL DRUGS

There was a clear distinction made between core interventions and services and those that were thought to be important but not to be implemented immediately:

"In addition to the issue of available resources, the other elements are the [Ministry of Health] MOH's and NGOs' technical and operational capacities to implement all elements of the BPHS. The MOH has closely examined these issues, and while mental health and disabilities deserve the attention of the health sector because they are significant causes of morbidity, they do make a smaller contribution to reduction of preventable mortality in comparison with other elements of the BPHS. Hence, it has been concluded that these two elements of the BPHS—mental health and disability—would be considered a "second tier" of the package and scheduled for phasing in at a later date." (Transitional Islamic Government of Afghanistan 2003)

The core service package was costed in 2002, using expenditures reported by some of the largest NGOs in Afghanistan. Disability and mental health services were not included in the costing at that time as they were second-tier services. The resulting figure of $4.50 per capita was used by donors as a guideline for funding the implementation of these services. This figure included the salaries of all health staff, for which a national salary scale was developed, with salaries graded by gender and remoteness in order to encourage the recruitment of female staff as well as increase staff recruitment and retention in remote areas.

In 2005, two years after implementation started, the newly established MoPH of the Islamic Republic of Afghanistan reported in the updated BPHS document (Islamic Republic of Afghanistan 2005) that the introduction of the BPHS had resulted in:

- Bringing coherence in and unification of the priorities of the Afghan health system
- Facilitating unambiguous decisions about the direction of the health system
- Standardising the classification of health facilities
- Increasing the proportion of the population with basic access to BPHS services to nearly 77%

The new health ministry also moved mental health and disability services to the first tier and added blood transfusion services, Voluntary Confidential Counselling and Testing (VCCT) for HIV/AIDS, and additional maternal health and family planning activities. These additional services were not costed, and the $4.50 per capita cost was still being used by MoPH and donors in 2009 to calculate budget needs for primary services. Although the scale-up of services was remarkable for such a short period of time, it must also be noted that the 77% coverage rate reported by the MoPH does not represent physical access to facilities, but was calculated based on the number of districts covered by services.

An Essential Package of Health Services (Somalia)

Unlike Afghanistan in 2002/2003, the political situation in Somalia continues to be unstable. The country consists of three distinct political zones (Somaliland, Puntland and the Central Southern Zone), each of which have their own form of governance, and there is no real capacity to make a centralised decision to re-build. This has had its repercussions on the development and implementation of what in Somalia is called the Essential Package of Health Services (EPHS). Development of the EPHS was a first core step in a broader HSS programme supported by the European Commission (EC). This initiative sought to build on local initiatives and do what was possible and useful, and not necessarily what was technically prescribed. By developing a standardised EPHS, the HSS programme was then able to move forward by addressing a range of other HSS building blocks including, among others, the development of costing tools and Human Resources strategies. It also contributed to a process of donor harmonisation which addressed issues of strategic focus and predictability of funding.

The EPHS package was developed as a very practical tool for strategic health system delivery, and is based on extensive input from MoH officials, health professionals, the UN and NGOs working

across all three zones. It is designed to be used by Regional Medical Teams, NGO and UN health programme managers and implemented wherever access permits as a tool to rapidly improve the quality of service provision and performance management. It is also designed to be used both in conflict affected and more stable areas by combining a humanitarian and health system strengthening approach.

Where the focus of the Afghan BPHS was on achieving *coverage* of scaled up services, in Somalia the decision has been made to focus on ensuring *quality* and improved management in targeted health facilities. The Priority 1 focus of the EPHS is on maternal health, based on the rationale that maternal health cannot be adequately addressed without a health system, and if these services can be adequately provided, then all other necessary services can also be provided in the given health facility.

The EPHS is implemented across four levels of service provision (primary health units, health centres, referral health centres, and hospitals), each with a standardised service profile that is encompassed in 10 specific health programmes (see Box 2, below). Nutritional interventions are integrated across the programmes, and water and sanitation initiatives are encouraged at community level in the Communicable Disease Control component. Of the 10 health programmes, there are six core programmes which are found at all four levels of service provision, and four additional programmes that are only to be provided at the referral levels.

BOX 2 - SOMALI ESSENTIAL PACKAGE OF HEALTH SERVICES

Core programmes implemented at all levels

1. Maternal, reproductive and neonatal health
2. Child health
3. Communicable disease surveillance and control, including watsan promotion
4. First aid and care of critically ill and injured
5. Treatment of common illness
6. HIV, STIs and TB

Additional programmes implemented only at referral level

7. Management of chronic disease and other diseases, care of the elderly and palliative care
8. Mental health and mental disability
9. Dental health
10. Eye health

Maternal health gets the biggest focus in the package as levels are near catastrophic. Equipping the current Maternal and Child Health Outpatient Departments (MCH-OPDs) to become integrated health centres with capacity for handling basic Emergency Obstetric and Neonatal Care (EmONC) is a priority, along with the creation of referral health centres that can provide safe blood transfusions and comprehensive EmONC. A key factor in the EPHS is having a properly trained and employed Community Health Worker (CHW) cadre, who do essential child health and family planning, but do not do deliveries. Traditional Birth Attendants (TBAs) are not included in the formal health system, and those that already exist are to be re-trained as CHWs or maternal health promoters, who are to promote institutional deliveries with trained midwives.

The EPHS will require a full range of health systems management inputs and logistical support components. These consist of a standardised set of six management and support components (Box 3) that are to be implemented at each of the four service levels.

BOX 3 - Six core management functions for the EPHS

1. finance
2. human resource management & development
3. EPHS coordination, development and supervision
4. community participation
5. health systems support components
6. health management information system

Three groups (health facility staff, the regional health office, and community health committees) are involved in running the health system, each with its own set of specific management roles and responsibilities which are defined in formal contracts that are to be signed between community representatives, the MoH and the implementing agent.

Health facility staff and community committees are encouraged to diversify the revenue base of the facility by looking to four potential sources of income: (1) the Central MoH; (2) the municipality or regional authority; (3) community contributions (including private contributions and diaspora remittances), and (4) donors. At hospital level only are user fees included for certain activities such as elective surgery or lab tests, but it is hoped that the essential primary health care package for women and children would be free of charge if sufficient funds are resourced.

The EPHS has not yet been coupled to a fixed per capita cost. Instead, complementary software has been developed to facilitate the costing of the package based on financial data collected as the different elements are implemented. A national salary scale for health staff and a standardized drug kit for distribution to health facilities (that is to be distributed through UNICEF) have also been agreed upon.

2.1.2 Mother and Child Health Services

One of the key elements of many packages of health services is the provision of maternal health services, as there is a clear link between maternal mortality and a weak health infrastructure: the majority of deaths during childbirth are preventable if the pregnant woman can reach appropriate health services in time. The same applies to child health services, where most of the mortality is due to infectious diseases that are often easily prevented and treated.

The provision of good maternal health services relies upon the ability to provide women with access to skilled birth attendants, contraceptives, magnesium sulphate and other basic commodities, blood transfusion (swiftly when required), and a sanitary environment and sanitised equipment to prevent infection (Marie Stopes International 2008). Maternal health services are naturally coupled to child health services, as mothers and young children generally visit health facilities together, and both benefit from Expanded Programme of Immunisation (EPI) services and health education. Child health services generally focus on children under 5 years of age, and also include the provision of essential newborn care, growth monitoring and control of infectious diseases.

Lessons learned in scaling up reproductive health services

Under the Taliban, Afghan women had extremely limited access to health services. With one of the highest maternal mortality ratios in the world at 1,600 per 100,000 live births (Bartlett, Mawji et al. 2005) and exceedingly low contraceptive prevalence rates, the availability of quality Reproductive Health (RH) services is key to saving thousands of women's lives in Afghanistan on an annual basis. In response to this, the Afghan BPHS includes reproductive health services as one of its key areas, and scaling up of these services has been significant in Afghanistan since 2003. However, rapidly scaling up services, especially in contexts where significant skilled staff shortages exist, is not without its limitations. For example, five years into the roll out of the BPHS in Afghanistan, including antenatal care, delivery care, post-partum care, family planning and care of the newborn, concern is being raised about the quality of the RH services being provided. Using results from the Balanced Scorecard, which is the third-party monitoring tool used in Afghanistan, Marie Stopes International (MSI) queries whether the RH elements, as they are currently being implemented, actually address women's basic health needs, particularly with regards to essential obstetric care and appropriate method mix for family planning.

Although the 2007 Balanced Scorecard results states that 86% of comprehensive health centres report to be managing routine deliveries (Ministry of Public Health of the Islamic Republic of Afghanistan, Johns Hopkins University Bloomberg School of Public Health et al. 2006), this may be overly optimistic. The same report indicates that only 22% of facilities visited report to be using the partograph, an essential part of managing routine deliveries. Additionally, management of incomplete abortion and post abortion care, essential components of basic emergency obstetric care, have not been mentioned in progress reports since the BPHS was implemented. Notwithstanding the fact that availability of family planning services has improved, the provision of these services appears to be lagging behind improvements in other areas. Yet reducing the number of pregnancies each woman experiences by using contraceptives is probably one of the most straightforward ways of reducing her chance of dying during pregnancy and childbirth (Prata, Sreenivas et al. 2009). Based on such findings, fragile states are encouraged not only to focus on family planning as a priority for scaling up RH services and reducing maternal mortality rates, but also to ensure that the correct and sustained use of basic tools and life-saving interventions are given sufficient attention in the scaling up of obstetric services.

Increasing demand for reproductive health services

Usually, priority is given to improving the coverage and clinical quality of safe motherhood services such as those described above, but many states and local governments lack the capacity, methodologies and tools to intervene effectively on the 'demand-side', which is equally, if not more important for access to reproductive health services. The DFID-funded Partnerships for Transforming Health Systems Programme (PATHS) developed a replicable approach for increasing demand for, and access to, emergency maternal health services within the context of a large-scale health systems strengthening programme in Kano and Jigawa, two primarily Muslim Nigerian states (Green 2008). In Jigawa the initial phase focused on 36 communities, later expanding to 90 communities in a second phase, and currently 174 communities in all Local Government Areas (LGAs) are included. In Kano 65 communities were initially included, with later expansion to a total of 93 communities.

Participating communities were involved in an innovative process of behaviour change, which was based on generating social approval for new behaviours. Community systems were established to tackle the household and community barriers of access to safe motherhood services, including emergency loan funds, emergency safe motherhood transport schemes, and blood donation

groups. In addition to addressing delays to accessing safe motherhood services at a community level, the initiative also focused on building institutional capacity within government to lead and sustain the work, and strengthening the technical and project management capacity of non-government implementing partners. Emphasis was also placed on use of advocacy and lobbying to leverage high-level political support for the work.

The work took place against a backdrop of health systems strengthening activity, which helped to create a reform mindset among government implementing partners, while tangible service delivery improvements created receptivity among community stakeholders. Although the implementation time frame was only 2-3 years, results from the project indicate that the community engagement approaches developed in both states appeared to be both culturally appropriate and effective. Significant behaviour change in relation to pregnancy and maternal complications occurred in the intervention communities, and communities and providers in both states reported that many maternal and neonatal deaths and morbidities had been averted. After one year of operation in the first batch of 36 villages in Jigawa, the percentage of maternal complications that resulted in a maternal death had halved. Monitoring systems in Kano provided solid evidence of very significant behaviour change in favour of a rapid response to maternal complications across participating communities. In both states there was evidence of a spin-off effect, as participating communities shared their knowledge and experience (and their community emergency safe motherhood systems) with neighbouring communities, which resulted in an overall coverage wider than just the targeted communities

Despite many challenges, the positive experiences in the two Nigerian states show that it is possible to address barriers of access, affordability and acceptability of safe motherhood services even in contexts where the barriers are profound, resources are constrained, institutional capacity is weak and concepts of partnership working with organisations outside government are not very evolved. The key is to work at buy-in at all levels, from the communities up to the highest political levels.

A community-centred approach to MCH for remote and under-serviced areas

Haiti is comparable to sub-Saharan Africa in its health indicators and the Human Development Index (HDI), but it is also ranked by Transparency International in 2008 as one of the most corrupt countries in the world (Transparency International). The Haitian Health Foundation's (HHF) Community-Based Primary Health Care (CBPHC) programme aims to improve access to health services and behaviour change to more than 225,000 of the poorest people in over 100 rural mountain villages in south-western Haiti. The area is very isolated, and even under the most favourable conditions communication is scant, with no health services for the poor. CBPHC is an integrated village or neighbourhood approach to assuring that no family, no child and no pregnant woman is left out of care. Its strengths are innovative health education, peer support, engagement of leaders, feedback to the community about progress, joint planning, and "keeping promises" on both sides. It is a mechanism to deliver basic maternal and child health services using a community-based approach and strengthening the next generation of youth through education, sports and community action. It is not easy and does not end at 4pm on Fridays to re-open again on Monday. Instead, the programme has demonstrated impact on improving the health of children under age 5 through its commitment to continuous service (since 1987) and partnership with the Ministère de la Santé Publique et de la Population (MSPP) in a chronically challenging context.

The foundation of the CBPHC programme consists of village Health Agents and community groups responsible for the provision of sustained preventive and basic curative care. Health Agents are

supervised by HHF nurses and medical doctors and evaluated frequently. These individuals and groups provide a platform for a wide variety of community engagement seminars based on trust. Topics range from human and reproductive rights to community development and problem solving. New health initiatives build on the successes of previous activities, and while pregnant women are given a critical focus, the programme also aims to involve men in family health issues. Once trust is established, communities provide what they can for the benefit of all – building structures, repairing access roads, or lending mules for transport. Community volunteers feed the malnourished, bury the dead, rebuild homes, and teach life fostering actions. Pregnant women are given a "birth plan" to assure that prenatal care at the community level follows a standard format, and that mothers and their families are prepared for the challenge of childbirth. The plan is a potentially effective mechanism to strengthen the partnership between the mother, her family, the community-based health care provider, and the health facility to reduce maternal and neonatal mortality. Referral to the maternal waiting home associated with the programme is encouraged for high-risk pregnancies.

The RH programme started in 1994. During an evaluation in 1998 it was found that the total fertility rate in the programme coverage area was 3.5, compared with a national rate of 5.0 for rural Haiti. It was also found that exclusive breastfeeding had increased from 66% in 1998 to 80% in 2008. Uptake of postpartum nurse consultations increased significantly over the years, and further behavioural changes, such as the use of colostrum instead of the traditional purgative for newborns, have also been noted. Additionally, since the start of the programme, HHF has documented a 50% reduction in the paediatric pneumonia death rate and increased uptake of vaccination and use of ORS in one of the poorest and remotest regions of Haiti. Over a period of 22 years, partnerships with the local MSPP and nursing school and NGOs have supported a new generation of health workers. The career development ladder for HHF volunteers and staff has led to village women becoming health agents, health agents becoming nurses, and nurses becoming managers. Links with US-based universities have led to operational research and the assurance of continued quality of services. The long-term commitment to the health of rural Haitian families has been the cornerstone to the success of the programme.

A community-centred approach to improving child health

In order to address the country's high maternal, infant and under-five mortality rates, the Afghan MoPH included Mother and Child Health as a priority service for its Basic Package of Health Services (BPHS). During two-years, from 2004 to 2006, Save the Children UK supported the Afghan MoPH in the implementation of BPHS in Jawzjan province under the REACH programme (Rural Expansion of Afghanistan's Community-based Healthcare). The purpose of the programme was to establish an equitable, accessible, quality health care delivery system through expanding the delivery system, improving the quality and increasing the local capacity for efficiency and sustainability. In addition, the organisation also worked closely with the communities, health facilities and MoPH to enable them, through training and involvement, to establish and sustain systems for supporting the survival rights of children.

The project team chose to take a systematic approach to ensure that various stakeholders, with a particular focus on the community level, had a good understanding of the BPHS as well as child rights. Firstly, discussions were held with the Provincial MOPH Director and Provincial Governor, then with the District Managers and finally with village leaders in each district. The village leaders then organised meetings at village level - for the whole community. During these meetings emphasis was put on the importance of community participation and representation of women and children in the health committees. Project team members were available for clarification on any points arising from the discussions. Communities were fully involved in the selection of CHWs

and village health committee members. Once the health committees were established, members were given two days of leadership training, including an orientation on children's rights and child protection, to prepare them for their role. The range of services provided at health facilities and community level were in line with the BPHS package, with a special emphasis on common health problems of children and women of reproductive age. In order to ensure optimal health services were available for children, Integrated Management of Childhood Illnesses (IMCI) protocols were introduced at all facilities. Additionally, child rights and child protection issues were covered in all trainings of health facility staff and Community Health Workers.

An end-of-project evaluation in 2006 found that integration of topics on children's rights into all the training related to health generated awareness and initiated changes in the attitude and practices regarding children and their issues. Health services at project facilities were more mother and child friendly than before. For example, health staff and CHWs reported changes in their own attitudes and behaviour towards children at home and in the workplace. Children were given priority for consultations and health workers talked kindly to children during examination and reassured them while giving immunisations or other treatment. The evaluation also found that children's participation in health committees was possible even in quite conservative communities, providing that parents were consulted and well informed of the purpose and nature of their children's involvement.

The project policy of ensuring representation of children and women on Health Committees challenged traditional views of women and children in society and gave them more voice. A total of 134 children became members of health committees (120 boys and 14 girls). This provided them with the opportunity to understand the availability of health services and raise their views and concerns about the health services. The additional leadership training given to the health committees provided the children with opportunities to learn about health services and how they could have a stake in monitoring and decision making, and Health Committee members were beginning to listen to the children and consider their views. The child-rights training given to the committees raised awareness among influential village elders and encouraged them to promote children's participation in a context where children traditionally had little voice. Health Committees and village elders were found to be actively supporting health facilities and taking an interest in the quality of services available for children and women. In addition to an increased awareness of child rights and child protection at all levels, the risks of morbidity and mortality for children and their mothers were reduced as a result of improved access to quality healthcare at health facilities. Specific policies, such as exemptions from the payment of registration fees for under fives, facilitated access to care. Although this community-centred approach to improving child rights seems to bear fruit, child rights awareness in Afghanistan still has a long way to go.

2.1.3 Control of Infectious Diseases

Although chronic diseases and injuries are major causes of death in developing countries, the highest burden of morbidity and mortality in the majority of fragile states is still attributed to infectious diseases. It is therefore not surprising that infectious disease control always has a prominent place in health services provision, no matter what type of health system is in place in a state at any given time. With increased funding being made available for infectious disease control through donors such as, for example, the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM), the Gates Foundation and the Clinton Foundation, the challenge in fragile states is not often one of financing, but rather one of determining priorities, choosing the most effective delivery strategies, and reaching remote and insecure areas. Interestingly enough, the fact that fragile states are exploring new models of service delivery and have less developed bureaucracies and infrastructures than more stable countries can sometimes lead to opportunities for rapid implementation of the newest treatments and control strategies.

Taking advantage of a post-conflict context to update and scale up treatment policies

Roll-out of Artemisinin Combination Therapies (ACTs) as a new first-line treatment to combat chloroquine-resistant malaria across Africa was initiated in 2002, more than two years after the drugs had been approved by the World Health Organisation (WHO). The process was challenging due to the fact that MoHs were cautious about introducing new and expensive drugs, and were often burdened by a lack of technical support, governmental bureaucracy, and sluggish response capacities. Liberia, recently coming out of a civil war, became one of the first two African countries to introduce ACTs as first-line treatment and was able to roll out the new policy within a year. Contributing to this rapid implementation were the availability and use of outside technical support, nascent policy processes which could move rapidly, willing donors, and the fact that the burden of implementation did not fall on the government.

By 2003, at the beginning of the post-conflict phase, over a decade of civil war had eroded Liberia's health systems infrastructure and regulatory mechanisms, and the MoH was almost entirely reliant on a network of about 20 NGOs and Faith-Based Organisations (FBOs) for health services provision. ACTs were not yet registered, were not on the essential drugs list and, notwithstanding NGO pressure, Liberia's MoH was wary about introducing an expensive drug about which it knew little. Regardless of this, with the onset of acute conflict in Liberia and mounting evidence of chloroquine resistance, NGOs working in Internally Displaced Peoples (IDP) camps got cautious approval on an informal basis to use ACTs as first-line treatment. The MoH went one step further in 2003, just after the acute phase of the Liberian conflict ended, by issuing a letter to NGOs tentatively changing the first-line treatment for malaria to ACTs on condition that staff were trained according to MoH guidelines, which had been developed in partnership with technical agencies working on the ground.

A number of factors came together to facilitate this process. Firstly, a number of NGO delegates and MoH personnel had received training on the use of ACTs through a Roll Back Malaria (RBM) designed and Johns Hopkins University-Mentor implemented regional course just prior to the acute emergency that occurred in Liberia in 2003. Thus, there was a critical mass of health personnel in Liberia who had gained an understanding of the new drugs and become sensitized to the need for policy change. In addition to this, Liberia's government, in a transition phase after the war, did not yet have complex administrative processes in place, was largely donor-dependent, and did not yet have an extensive health system to support. Drug policy protocol changes were initiated in the first instance through a stakeholders workshop held by the National Malaria Control Programme (NMCP) with technical support from partners to discuss applications for Global Fund proposals. The workshop was used as a channel through which technical partners began to discuss malaria drug resistance with the NMCP and NGOs. During this workshop, findings of efficacy studies that had been done in the country by NGOs and the MoH were re-visited and WHO guidelines (which stated categorically that emergency phases warranted switching to ACTs) were consulted. In addition to this, key donors in Liberia were advocating the introduction and use of ACTs and pledged financial support for a new policy.

In July 2003, the Liberian MoH officially adopted a combination of Amodiaquine (AQ) and Artemisinin for use as first-line treatment for malaria. The roll-out of this policy was done not through the routine health system, which was largely dysfunctional, but through partnering with the NGOs providing health services in the country. Due to their greater flexibility and responsiveness, the NGOs were able to scale-up from 6 sites in September 2003 to covering the majority of the accessible sites in the country by December of that year. The NMCP-chaired consortium supported introduction of the drugs by having Médecins Sans Frontières (MSF) share its experience with rolling out the drugs and the challenges they faced (i.e. the lack of acceptance of AQ), having donors commit to ensuring continued supply of ACTs, and utilising the technical

assistance of Mentor for monitoring and coordination of the efforts. As insecurity decreased over time and other parts of the country became more accessible, the consortium was able to support gradual introduction of ACTs into new areas of the country, saving the lives of many that may otherwise have died from malaria.

Community Case Management for infectious diseases

Worldwide, ten million children die each year of preventable diseases, half of which are due to three conditions: pneumonia, diarrhoea and malaria. Many of these deaths occur in fragile states where health service delivery systems are weak and sometimes non-existent. Nevertheless, these diseases are partly preventable and nearly entirely treatable with simple regimens of relatively inexpensive drugs. Although several randomised controlled trials have shown that community health workers (CHWs) can effectively categorise and treat children with these conditions using Integrated Management of Childhood Illness (IMCI) criteria, this strategy is seldom implemented in fragile states. This is because, although WHO and UNICEF endorse the strategy, and there is evidence of a reduction in child mortality as a result of this approach, some organisations have expressed concern that CHWs cannot be adequately recruited, trained and supervised in the context of fragile states.

The International Rescue Committee (IRC) has worked with local partners to set up Community Case Management programmes in Rwanda, Sierra Leone and Southern Sudan, covering nearly 1.4 million people, including nearly 250,000 children under the age of 5. In these countries, the IRC and its partners have approached communities, facilitated the selection of CHWs, and trained, equipped and supervised these workers. CHWs assess and treat sick children for pneumonia, diarrhoea and malaria, and refer children with danger signs or other illnesses. CHWs receive no financial compensation through the programme, but are supported in various ways by their communities.

Through these programmes, CHWs treat around 22,000 children each month. Supervisors provide 0.8 supervisions per month in Southern Sudan and 0.3 in Sierra Leone (with no data available for Rwanda). Between 2005 and 2007, mortality of children under 5 in programme areas decreased by 48% in Sierra Leone and 81% in Southern Sudan. Adult and older child mortality has remained stable, and overall child mortality in these two countries decreased only slightly during the same period.

Harm reduction in a muslim community

In a recent report, UK's Department for International Development (DFID) reported that the proportion of people living with Human Immunodeficiency Virus (HIV) is four times higher in fragile states that in other low income countries, while the capacity of fragile states to take action is considerably lower (DFID 2008). In many fragile states in Asia, the primary risk factor for HIV transmission is needle-sharing by Injecting Drug Users (IDUs). This requires an approach different from the Behaviour Change, VCCT and Anti-Retroviral Treatment (ART) programmes which form the cornerstone of HIV/AIDS control most African countries.

Although China has a strong central government, a number of its autonomous regions suffer from the lack of human and financial resources, technical expertise and adequate infrastructure common to many fragile states. In Yining city in the Yili prefecture of the Xinjiang Uyghur Autonomous Region, which is predominantly muslim, a harm reduction project was started in 2003 to address the increasing numbers of HIV cases being reported among IDUs. A comprehensive approach aimed at preventing further HIV transmission and reducing stigma and discrimination directed towards HIV-positive people and IDUs. The programme included a community mobilisation component targeting government leaders in health and law enforcement,

local community and religious leaders, and the general public as well as IDUs, people living with HIV/AIDS (PLWHA) and their family members and friends. This was done through strategic training courses, campaigns, and community activities. In addition, a needle and syringe exchange programme (NSEP) was implemented through volunteer street patrols and street outlets. Sometimes run by ex-users, they provided clean needles, collected and destroyed used needles, and provided condoms and information about safe sex.

One year after onset of the programme, significant positive changes were noted in community support for IDUs that enabled access to information and needle and syringe exchange. Sharing of needles and syringes among IDUs decreased by 52%, and condom use among IDU couples increased by 44%, while visits to commercial sex workers had halved while condom use had increased by 38%. Residents reported that police were keeping away from areas where the NSEP was active and felt that the police were supportive of the programme, and commented on the lack of discarded needles and syringes that had previously littered the streets. An additional key to success was the collaborative effort among agencies working in Yining City to provide additional testing, community care and treatment activities, which has led to a comprehensive and sustained approach to addressing HIV/AIDS.

2.1.4 Immunisation

The Expanded Programme on Immunisation (EPI) is probably one of the most cost-effective life-saving interventions, yet a study conducted in 2007 found that for 19 fragile states, the median basic immunisation coverage rates were roughly half that of the 37 non-fragile developing countries with which they were compared (Davidson R. Gwatkin, Rustein et al. 2007; Ranson, Poletti et al. 2007)). There are three components of the EPI system. These are (i) Routine Immunisation (ii) Accelerated Disease Control (ADC) which comprises the campaigns, also known as Supplemental Immunization Activities (SIAs) and child health days (CHDs) and (iii) Vaccine Preventable Disease (VPD) Surveillance, targeting polio, measles, neonatal tetanus (NT) and, in some countries, yellow fever. Commonly used tools for implementation of these services include micro-planning and WHO/UNICEF's 'Reach Every District' (RED) approach.

Using RED as a foundation for health services delivery in poorly accessible regions

In Papua New Guinea (PNG), a principal difficulty in providing adequate health services to rural and remote populations is the extremely high transport costs due to the difficult terrain. The Momase Region of PNG comprises of four provinces and 25 administrative districts. Only two of the provinces can be reached by road, with parts of the road frequently impassable due to weather conditions. Banana boats are used to reach coastal islands and towns, while in mountainous regions a 10-14 day walk may be required. Although airstrips are scattered through the region, flights are costly and seats difficult to obtain.

An operational strategy was needed to overcome the cost barriers to improving rural health. WHO and UNICEF have introduced and widely implemented the RED strategy of decentralised capacity building, which consists of a rigorous application of the micro-planning technique used in community development, relying on planning at the lowest unit of population. RED has been successfully introduced in other countries, but primarily in situations with easy access to low cost transportation, where bundling programmes was not a high priority.

In Momase, the RED strategy was implemented to increase immunisation coverage at the level of district or health centre catchment areas, but it was also felt that the operational components of the programme, including planning, implementation and monitoring, could be readily adapted to other population-based interventions. The strategy was therefore implemented in late 2007 as the basis for an expanded strategy called 'Reach Every Village' (REV), which will add malaria, safe

motherhood, Tuberculosis (TB) and Sexually Transmitted Infections (STI)/HIV treatment and prevention to immunisation services provided through RED. Where successes are booked, additional public health interventions will be added gradually. The approach is aimed at all health facility catchment areas, including Aid Posts, and uses the initial micro-planning results as a foundation for planning all services. In the operating environment in PNG, particularly with its minimal resources, isolated staff and low staff morale, it is expected that this will have a significant impact on efficiency, as well as providing a more holistic approach to health.

Only the results of the initial pilot were available at time of writing. Training for the strategy was done first during a central workshop, and thereafter at district level, focusing on micro-planning for EPI services. Participants were trained to complete key tasks relating to their own catchment areas which included:

- Mapping of health facility catchment areas including key infrastructure (buildings, roads, population figures)
- Completion of planning sheets on staff, material and time resources needed for implementing EPI activities. Due to the severe access constraints, it was decided that each village only needed to be visited once every 3 months rather than monthly as was the routine for EPI services elsewhere
- Preparation of budgets for transport, accommodation, equipment and running costs
- Charting of activities conducted during previous years to provide a baseline for monitoring and determining progress at a local level

Some of the benefits of completing micro-planning as a group activity included the ability to share creative solutions to overcoming transport constraints, redrawing catchment areas to facilitate better access, coming to common agreements on increased requirements for staff time to meet targets, exploring ways to come up with more reliable population figures, overcoming constraints related to finances, materials and maintenance, and the discussion of the possibility of combining RED with supplementary immunisation activities and other health services activities such as TB treatment, nutrition, family planning, antenatal care and school health. Crucial to the programme's success, a simplified reporting and monitoring approach was adopted along with the concept of supportive supervision. Follow-up visits indicated that health facilities were starting to use monitoring charts not only for EPI but also for other family health programmes. Staff expressed their content with the simple reporting systems and the improved capacity to communicate with supervisors and address key problems.

2.1.5 Mental Health and Disability

The populations of conflict-affected fragile states generally suffer from significant levels of mental distress including depression, anxiety and post-traumatic stress disorder resulting from excessive exposure to violence and other traumatic events, forced displacement and other mental and economic distress (de Jong, Komproe et al. 2003; Mollica, Cardozo et al. 2004; Scholte, Olff et al. 2004). Disability is also prevalent, and while primary cause of disability is poor mother and child care services, there is an increased prevalence in (post-)conflict states, as both soldiers and civilians are at high risk of injuries from active fighting, landmines, bombings, and in some cases, the deliberate targeting of civilians. Countries such as Sierra Leone, Angola and Afghanistan struggle with the high burden of mental ill health and disability, but with the exception of Afghanistan, public health services generally do not cater to these needs. As a result, such services are often primarily addressed at a grassroots level, with larger programmes frequently limited in terms of coverage and sustainability. In recent years Mental Health and Psychosocial Services (MHPSS) in fragile states has been receiving more attention after the publication of a number of prominent reports and guidelines (Baingana, Bannon et al. 2005; IASC 2007).

Prioritising Mental Health and Disability services

In 2003, Afghanistan put mental health and disability services prominently on the agenda by including them as key elements of the BPHS services. In order to establish the need and possible target population for mental health and disability services, Handicap International (HI) conducted a national disability survey in 2005, which included mental health as an outcome indicator (Trani and Bakhshi 2006). The MoPH also established Mental Health and Disability Departments in 2005. Although key elements for a successful national mental health and disability programme were in place, there were also significant constraints. It was, for example, unclear what shape or size these services were to take, and financial support was not forthcoming. Where MCH could come up with a clear and costed package of tested interventions, mental health and disability services lagged behind, unsure of the best approach to take and interventions to pursue. It was therefore also difficult to come up with human resources requirements, training requirements, material requirements and crucially, a budget. In addition, although mental ill health and disability affect the health and wellbeing of a significant proportion of the population, some of the major donors did not wish prioritize these conditions because of a lack of demonstrated impact on mortality, which was their primary outcome of interest.

Six years after putting mental health and disability on the agenda, and four years after moving it into the first tier of services to be provided through the BPHS, the progress that has been made towards the provision of these services has been limited. When compared to other BPHS components, scaling up of these services (which should theoretically be available in all BPHS facilities by now) is going at a snail's pace due to three main reasons: lack of qualified staff, a continued lack of awareness of physiotherapy and rehabilitation services among BPHS staff, and crucially, a lack of donor support.

Currently a number of pilot projects provide mental health services while private initiatives have contributed to building up a small cadre of physiotherapists and mental health counsellors. Integration of these initiatives into the public health services has been exceedingly slow. Even the NGO-run Physiotherapy Institute, which falls under the MoPH's Institute of Health Sciences and is the only training facility to supply the physiotherapists required for the disability services of the BPHS, faces an annual challenge of finding funding and adequate premises to continue its services. Although the training curriculum has recently been expanded from 2 to 3 years, it has taken considerable efforts on the part of the MoPH Disability department to gain recognition of the training curriculum and the physiotherapy profession by MoPH's Directorate of Human Resources. It is expected similar constraints will be faced with the proposed introduction of psychosocial counselling through the BPHS (see below).

The key lesson learned is that even though the need for services may be obvious and commonly agreed upon, more research is needed on determining cost-effective interventions with a demonstrable impact on population health in order to support advocacy and stimulate donor support. Clear plans have been developed and costed for the implementation and scaling up of mental health and disability services in Afghanistan, which clearly outline the services to be provided at each level of health facility, training and human resources requirements, material requirements, job descriptions, and costs for each of these components. But until now, the provision of mental health and disability services continues to rely on the goodwill and hard work of a small number of dedicated organisations and individuals, and has not yet been integrated into the BPHS in a comprehensive manner.

Addressing disability through Community-Based Rehabilitation

Although disability services as provided through the BPHS appear to have landed on the back burner in Afghanistan, a number of NGOs, with the support of various ministries and UN agencies, are in the process of addressing disability through the mechanism of Community-Based Rehabilitation (CBR). CBR has been described in terms of a framework of *goals*, *principles*, and *areas of activity* (World Health Organisation):

- ***Principles***: participation, inclusion, sustainability, and self-advocacy.
- ***Areas of activity***: health, education, livelihoods, empowerment, and social integration.
- ***Goals***: human rights, socio-economic development, and poverty alleviation.

CBR is an inter-sectoral, comprehensive rehabilitation and social mobilisation programme which falls mostly outside the health sector. In Afghanistan, CBR is being coordinated by the MoPH Disability programme, and components include physical rehabilitation, special and inclusive education, employment support, community mobilisation, and the facilitation of self-help groups and support to Disabled People's Organisations (DPOs) in districts and provinces.

There are two target groups for CBR in Afghanistan: (1) those who are physically disabled (including motor, sensory and learning disabilities) and (2) those who are disabled as a result of mental illness. It is important to note that the national disability survey (Trani and Bakhshi 2006) showed significant higher prevalence of mental health problems among the population of people with disabilities as compared to a non-disabled population. Although contended by CBR experts who strongly feel CBR should focus on providing support to persons with physical disability, in the Afghan context it is felt that persons with disabling mental health problems but *without* other disabilities should also be included in the CBR programmes. There are some preconditions, such as the possibility of referral to psychosocial counselling and treatment, and training of CBR workers in "case management" for mental health conditions. For this reason, a comprehensive training manual, the "Resource Book on Psychosocial Rehabilitation" has been developed for CBR workers and volunteers which includes the following topics:

- The definition of disability and mental health
- Popular attitudes and beliefs concerning disability and mental illness
- Basic typology and symptoms of mental illness
- How to interview people with mental health problems and other disabling conditions
- How to communicate with and advise individuals and families

CBR is currently being implemented and supervised/monitored by three international NGOs and a number of smaller national NGOs. Not all implementers cover all components of CBR, but all work on the basis of family and community support and interaction. By late 2008, the geographical coverage of CBR included 16 out of 34 provinces (but only 22% out of 366 districts). Services are being provided by about 800 experienced CBR workers and physical rehabilitation staff and over 2000 volunteers, all of whom have demonstrated good knowledge on local resources as well as programme constraints. The impact of the programme has not yet been evaluated.

Providing basic mental health care through public and community structures

That mental health needs to be addressed in Afghanistan is beyond question, as even the Afghanistan National Development Strategy (ANDS) makes mention of the need to address mental health at a population level (Islamic Republic of Afghanistan 2008). The key question here, as in all post-war and developing countries, was 'how', not 'if'. In 2002, in the Eastern province of Nangarhar, HealthNet TPO initiated a programme to (1) introduce and integrate mental health

issues (including learning disabilities and epilepsy) into the BPHS and (2) to provide culturally appropriate, community-based psychosocial services. The backbone of the programme was a core group of six psychosocial workers and four medical doctors who followed an intensive two-month training course.

For each service level of the BPHS, training modules and a supervision system were developed. For health posts, staffed by (non-paid) community health workers, a three-day training course was provided which focused on identification of persons with possible mental health problems in the community, and follow-up of patients with chronic mental illness. For staff of the basic health centres (BHC) and comprehensive health centres (CHC), ten-day training courses were organized. The training for doctors focused on diagnosis and bio-psycho-social management of the most important mental disorders, whilst the training for nurses and midwives focused on basic principles of non-pharmacological mental health care management, including empathic listening skills and providing social support. This approach was new for the health staff, and it was a challenge to introduce psychosocial competencies in nurses and midwives. For the district hospitals in the province, outpatient and inpatient services were made accessible for patients with mental problems, and each hospital has a mental health focal point: a full time medical doctor responsible for referral cases from the surrounding health facilities. At present, supervisors of the mental health programme visit these trained health staff at least once a month, although mental health is gradually being integrated into the tasks of the general health care supervisors.

Community based psychosocial services focus on social action and self help. It consists of several components: (1) Mobilisation of key figures: the team members identify strong, powerful individuals (‘key figures’) within communities or organizations who are willing to work as volunteers. These key figures can be community leaders, health workers or teachers. It is a particular challenge to identify influential female figures, but experience shows that in every community women are willing to undertake action to improve existing practices in order to reinforce their well-being. In each community the psychosocial workers, together with the key figures, identify existing and non-existing resources through a participative process of (2) community mapping. (3) Psycho-education is used to provide information to the population about psychosocial and mental health problems, what people themselves can do to alleviate these problems, and where they can find referral options, which need not necessarily be limited to the health services. Topics for psycho-education include ‘grief and sadness’, ‘drug use’, child rearing and children’s problems, family and domestic violence, etc. Another community based psychosocial method is (4) group work, in which people who have a common interest or a common problem come together to discuss a problem, receive mutual support and learn from each other. For some people the psychosocial workers offer (5) individual sessions.

As a result of the basic mental health training given to doctors, nurses, midwives and CHWs, the number of consultations for mental health problems increased from 0.8% of all consultations in 2002 (for 7 districts of Nangarhar) to 9% of all consultations in 2006/2007 (province-wide) and 15% of all consultations in 2008 (for all *rural* districts of Nangarhar). Most commonly diagnosed mental disorders were depression (66%), anxiety disorders (14%), epilepsy (10%), psychosis (4%) learning disabilities (2%), and substance use disorder (1%). Additionally, the community-based psychosocial component of the programme organized psycho-education sessions, support groups of around three to ten sessions, and individual sessions benefiting thousands of people. The costs to organize these basic mental health and psychosocial services were around 0.27 euro per capita.

During an external evaluation of the project in November 2008 a small survey was done among patients diagnosed with a mental health illness at the CHC or district hospital (n=38). The patients in the district hospital had visited the doctor between 3 and 10 times. All patients reported a clear

improvement in their perceived emotional and mental state and reported an increase in their ability to perform regular work, household duties and maintain social contacts. The psychosocial component of the treatment in the health care system tended to be given less emphasis, however, and particularly with common mental disorders such as depression and anxiety, there was a risk that treatment by medical staff would concentrate on biological treatment (medication), while ignoring the social context in which the symptoms occurred and were maintained.

Integrating psychosocial counselling services into a national service delivery mechanism

Although initially the mental health component of the Afghan BPHS tended to emphasize the prescription of psychotropic medications, a new psychosocial element of the BPHS was introduced and formalized in 2009. Evidence collected during a pilot scheme in Kabul from 2004 to 2008 indicated that most psychosocial problems were expressed in a primarily depressive and somatic pathology, and had been treated with uncontrolled medication or self-medication. In response, a group of 30 psychosocial counselors was trained over a 2 year period, using a curriculum which had been carefully adapted to the Afghan social and cultural context. In the 10 counseling centres that were subsequently established, more than 11,000 patients were treated over a period of nearly 4 years. Results indicated that 70% of patients left the centres with (self-reported) significant improvement, no longer requiring medication. Depressive symptoms disappeared in those cases where underlying psychosocial stressors were identified and better coping and resource-oriented problem solving was achieved through the counseling sessions. Additionally, among those treated, domestic violence was reported to have reduced, and the family as a functional support unit was reported to have strengthened.

Based on the evidence from these pilots, a psycho-social approach to mental health services provision will be scaled up and integrated into the BPHS on a trial basis in three provinces. This will involve appropriate technical training of BPHS staff at all levels, including the CHWs who are seen as the first point of contact. Basic counselling services will be delivered in the Basic Health Centre by male and female staff who will have received extra training. One male and one female professional psychosocial counsellor will be added to every Comprehensive Health Centre, which has a catchment population of 60,000. Psychotropic medications, if ultimately necessary, will be prescribed at the level of the CHC's and district and provincial hospitals after patients have been carefully screened. Teamwork models will be developed to strengthen the proposed vertical and horizontal referral mechanisms, as referral is to take place not only within the BPHS framework, but also to community based support groups such as, for example, the CBR programme mentioned in the previous section of this report. The pilot schemes will be evaluated in 2010.

Instead of seeing mental health as a stand-alone health service, it is to be introduced as a cross-cutting issue in Afghanistan, solidly integrating it into the routine services provided through the BPHS. It is felt that this integration process will result in the provision of a more holistic package of health services which respects the interdependence of mental, physical and social well-being. Without the provision of targeted, culturally appropriate mental health services in fragile states, it is highly likely that social and economic rehabilitation of the population will continue to falter.

Integrating existing mental health services into government structures

Where the Afghan examples given previously describe the challenge of developing a model for the provision of public mental health services from the start, the following example describes how non-governmental mental health services were slowly integrated into government health services over time. Burundi, situated in the Great Lakes Region, has experienced cyclic outbreaks of violence since its independence in 1962. Two major conflicts, one starting in 1972 and a second one lasting from 1993 to 2003, resulted in considerable political and social upheaval, causing

significant population movements and resulting in the destruction of socioeconomic infrastructure in the whole country. It is in this context of poverty and lack of basic needs, such as lack of shelter, health care, and damaged social infrastructures, that in 2000 HealthNet TPO started a programme providing psychosocial and mental health services to the war-affected population.

Over the years, the programme has developed from a pilot project consisting of nine psychosocial assistants working and living in the communities they assisted, to a multi-pronged approach that aims to support the government of Burundi to independently provide mental health and psychosocial services as part of its regular care. Close collaboration with various ministries assists in the decentralisation of the mental health services and their integration into the general health services. Activities include training and supervision at all levels of health services provision:

- Training in psychiatric care for government nurses and doctors in provincial hospitals in order to prepare them to take over mental health services. Each nurse received a basic training of 10 days each, a clinical ‘stage’ of five days, and a refresher training of 10 days. The doctors of the provincial hospitals receive an introduction training of five days with additional follow up trainings.
- Training and supervision of psychosocial assistants of the ‘*Centres du Développement Familiales*’ (CDF), part of the Ministry of National Solidarity. As community support structures develop, the role of the psychosocial assistant will become more and more that of a trainer and supervisor who will only assist the most severe cases.
- Training in basic psychosocial care to ‘natural community structures’, for instance women’s groups and other grassroots organisations, which allows communities to independently handle issues when the psychosocial assistant is not available.
- Training of staff of other NGOs in the provision of psychosocial services.

In order to facilitate these trainings, most training modules were developed and validated by a joint commission consisting of NGO, Ministry of Public Health, and WHO representatives. Community based psychosocial training modules were jointly prepared with the Ministry of National Solidarity. This final structure for services provision allows for mental health and psychosocial support and referral from grassroots community level, all the way up to the more specialised mental health care provided through a semi-permanent (two days per week) mental health service at the provincial hospital, which is staffed by trained government nurses and is fully integrated into the hospital services. Services at the highest level are implemented jointly with the government.

During almost a decade of system development, which saw the service provision framework gradually refine itself to its current approach, mental health and psychosocial support has been put more firmly on the policy agenda in Burundi. In seven provinces services have now been handed over to community volunteers and the government, while in other provinces this process is on its way. In addition, several local NGOs have started to provide services, allowing HealthNet TPO to focus on developing models of care for specific groups such as former child soldiers, returning refugees, and survivors of Sexual and Gender Based Violence. Advocacy for inclusion of mental health in the performance based health care financing is also underway. Challenges in the process of handing over of survives are the weak capacity of the governmental services to pay salaries in time, and to organize the logistics (for example the provision of essential psychiatric drugs to the health facilities). Support of an international NGO to organize clinical supervision and ongoing training will continue to be needed for the next years.

2.1.6 Nutrition

As is the case with mental health and disability services, nutrition services mean different things to different people. Where one expert focuses on maternal nutrition and improved birth weight, another might want to address micronutrient deficiencies and a third thinks nutrition programmes should focus on chronic and acute malnutrition in children under 5 years of age. Fragile states experience widespread prevalence of malnutrition in all age groups, especially women and children, and all of these issues, as well as several other functional aspects of nutrition, are directly related to health programmes. Health and nutrition are complementary, and until and unless nutrition measures are made an important component of a health strategy, key health targets are unlikely to be reached. Similarly, without a sound health-care strategy, nutrition measures, however well conceived and executed, will have very marginal impact. Nutrition planners and programmes have become disenchanted with the marginal impact of un-integrated, vertical nutrition programmes which often failed to reach areas where they were needed most, and are exploring alternative means of delivery of nutrition services.

Integrating nutrition into routine services provision

Nutrition has been integrated into the Afghan BPHS, but not surprisingly, along with mental health and disability services, it is probably one of the weakest service streams currently being provided. In the proposed Somali EPHS, nutrition does not consist of a separate service stream, but instead has been integrated across the programmes and makes use of the simplest tools available. For example, with the support of nutrition experts, it was decided to take out routine Weight-for-Height (WFH) monitoring as, in the Somali context, it was not producing any useable data. Instead, it has been replaced with screening using the Mid-Upper-Arm Circumference (MUAC) measurement, which is relatively straight-forward to implement and understand, even by illiterate CHWs (although it must be noted that WFH measures will remain in use as admission and discharge criteria for therapeutic feeding centres). Also, where in many contexts outreach services focus only on EPI, in Somalia the outreach teams will consist of one EPI officer and one nutrition officer. Their duties will be to not only conduct EPI and out-patient therapeutic nutrition programmes in the health centres, but primarily to do outreach clinics in the primary health units, where they are assisted by the CHWs. They will promote exclusive breastfeeding, provide nutrition counselling, advise on nutrition issues for sick children and adults, administer Vitamin A, iron/folate and/or micronutrient supplements, and refer both children and adults to supplementary feeding or therapeutic nutrition programmes as required and available. Finally, as acute food shortages and associated increases in global malnutrition levels are a regular occurrence in Somalia, sentinel sites that still use the more sensitive WFH measure will remain in place under the Somali Food Security Analysis Unit (FSAU), with sites run by UNICEF/NGOs.

Vitamin A supplementation during Child Health Days

Fragile states such as the Democratic Republic of the Congo (DRC) and Zimbabwe are characterized by low demand for health care services and high mortality rates. In the DRC, the economic opportunity and the social benefits of delivering child survival packages rather than stand alone interventions were perceived as early as 1998 when polio immunization was delivered through national vaccination days. Bringing key preventive health services into communities ensures that they reach children in remote regions where inadequate transportation infrastructure and/or war and social turmoil make routine services inaccessible to large portions of the population.

Because of the collapse and ineffective coverage of routine health services in both the DRC and Zimbabwe, Child Health Days (CHDs) were adopted for the delivery of biannual Vitamin A Supplementation (VAS). Built on the model of national polio immunization days, CHDs use

community volunteers to bring interventions into communities twice a year, thus reaching children who are not brought to health centres to receive routine preventive treatments. Using mass mobilization campaigns, VAS are delivered with other high impact child survival interventions that can be easily and safely delivered by non-medical volunteers, including immunisations, bednets, de-worming, and mectizan for onchocerciasis control. For example, in 2005, a national survey in the DRC revealed that 57% of children where anaemic; this resulted in mebendazole integration into VAS distribution for children 12 to 59 month of age. Helen Keller International (HKI) supports host government counterparts and UNICEF in planning for CHDs, training health workers, developing social mobilization materials, strengthening vitamin A capsule supply and logistics management, and programme monitoring and evaluation.

Approximately 26 million children in the DRC and 1.6 million in Zimbabwe received access to life saving interventions through CHDs. In 2008 the DRC achieved VAS and de-worming coverage of over 90% in the accessible health zones, in addition to vaccinating over 4 million children under five against polio. In Zimbabwe, a national VAS coverage of over 80% was achieved. Immunization rates in Zimbabwe were also bolstered by CHDs as most children receive routine immunizations only through this mechanism. This is because routine services are non-existent or people do not have resources to travel to health facilities. Although CHDs are a useful platform for nutrition interventions, since 2005 measles or polio vaccination have only been delivered through supplementary vaccination activities (SVA) to address punctual outbreaks, requiring synchronization of emergency and routine activities using the same delivery mechanism.

2.1.7 Chronic diseases

Chronic diseases and related risk factors impose a significant burden on the poor. It is only in sub-Saharan Africa that the burden of infectious disease is greater than that of chronic diseases. But even here, the trend is towards a dual burden, with deaths from chronic diseases projected to overtake those from infectious diseases in the next ten years (World Health Organisation 2005). The epidemic is largely driven by three major risk factors – tobacco use, poor diet and lack of physical activity. Underlying socioeconomic determinants, such as the lack of education and poverty, which tend to be higher in fragile states than in many developing countries, greatly exacerbate these risk factors. The global recognition and response to this threat has not kept pace with the epidemic. This appears to be especially the case in fragile states, where health services priorities tend to be donor-driven and focus on infectious diseases, while treatment of chronic diseases receives little to no funding and attention. Yet these diseases can have debilitating health effects if untreated, and result in serious financial consequences for families, especially the poor, if treatment is sought in the private sector (Suhrcke, Nugent et al. 2006).

Peer educator networks for diabetes

In Cambodia, half of the morbidity and mortality is due to chronic Non Communicable Diseases (NCD) (World Health Organisation 2005). Among adults older than 25 years, 5% in rural areas and 10% in urban areas have diabetes, an additional 10%-20% have impaired glucose tolerance and similar numbers have high blood pressure (King, Keuky et al. 2005). Publicly provided care is not available, while private care is unmonitored, of poor quality and expensive, which causes many patients to fall into poverty or remain poor. Cambodia's health services cannot meet the enormous and rising needs from people with chronic NCD, and innovative approaches are required to mitigate the impact of the rising epidemic.

Since 2005, MoPoTsyo, a local NGO, has been establishing community-based diabetes 'peer educator networks' in Cambodia. Peer Educators are patients who have diabetes but who are successfully self-managing. In addition, they have been trained to detect other people in their own

community who also have diabetes and to share their knowledge and skills in self-management. They counsel and support the newly found patients on how to measure presence of urine glucose and interpret the results. The Peer Educators report patient progress to a centralized patient follow-up system. In addition, they coach new patients to seek professional care from diabetes service providers accredited by the NGO to perform services for its members. Once registered as member of MoPoTsyo, new patients are first exposed to life-style changes and experiences of others in their own community to help them come to terms with their disease. They are encouraged to apply these life style changes themselves during several months before going to see a doctor and getting a prescription for generic medicines. The NGO operates a revolving drug fund to ensure adequate supply of affordable and good quality medicine to its members via contracted private pharmacy outlets, which are supervised by the peer educators and registered patients. Twice per year, the NGO uses random sampling to assess how patients are doing in terms of their understanding of the disease and how to bring it under control, their self recording in their own patient book, their well-being, their health related expenditure, and their adherence to prescriptions. Bio-medical markers such as Fasting and Postprandial Blood Glucose, HbA1c, Creatinin levels, Blood Pressure, and body weight are also measured.

A study based on analysis of routine monitoring data on blood glucose, blood pressure and body weight for 386 rural diabetes patients enrolled in the programme for at least three months, and data from two assessments of a random sample of these patients carried out in July 2008 and January 2009 showed that after 18 months, 10 peer educators had found 474 diabetes patients, two thirds previously unaware of their condition. The data on these new patients indicated improvements in Fasting and Postprandial Blood Glucose and Blood Pressure, even though half of them had not yet consulted a doctor. Their reported health expenditure appeared to be considerably more affordable than that of most diabetes patients in Cambodia. Experience has also taught that urine glucose strips are helpful tools for diabetes patients in low income countries, as they are more affordable than blood glucose strips, and are effective in particular for detecting postprandial glucose peaks. In the absence of a massive government or international response to the unmet needs of people in post-conflict countries where chronic diseases such as diabetes are often not included in the priority interventions of a Ministry of Health, peer educator networks may play a useful role in mitigating the disease’s negative impacts by providing a low cost but effective care structure despite a low resource environment.

2.1.8 Hospital services

Traditionally the primary focus of health systems in fragile states has been the provision of hospital services. Nevertheless, due to lack of funding, infrastructure, and occasionally human resources (many of which frequently get diverted to the military in the context of states in conflict), even this component of the public health system is often dysfunctional. It is also often the service component which nascent Ministries of Health are most keen to rehabilitate and make operational as soon as possible after they are appointed, for functional hospitals are often seen as a status symbol by Ministry officials and the population alike. This is facilitated by donors, who like quick-impact programmes that yield positive images for the reports to their constituencies.

Hospitals are primarily located in cities and larger towns in developing countries and rarely offer preventive health services, which limits the overall impact their services have on population health. The package of services they should offer, as well as the coverage area, is often a subject of debate. The challenge of management, quality assurance, service delivery and financing of hospitals are considerable, even for industrialised nations.

Organising services: An Essential Package of Hospital Services

The Afghan BPHS was instituted in 2002 to ensure health services delivery to rural areas, as this is where the majority of the population lived. However, it was recognised that the referral system was incomplete and tertiary services were a crucial component of the health system, especially with respect to Emergency Obstetric and Neonatal Care (EmONC). The BPHS was therefore complemented, in July 2005, by the Essential Package of Hospital Services (EPHS) (Islamic Republic of Afghanistan 2005) which classifies district, provincial and regional hospitals according to the size of the referral population, the number of beds, staff workload and complexity of patient services offered. Under the EPHS, hospitals at each of these levels provide four core clinical functions: medicine, surgery, paediatrics, obstetrics and gynaecology. The ultimate purpose for the development of the EPHS was to improve the quality of hospital services provided to the population of Afghanistan.

Scaling up of the EPHS is going at a much slower pace than the BPHS. One of the reasons may have been that provision of hospital services is far more costly than the provision of Primary Health Care (PHC) services and donors had already allocated considerable budgets to BPHS service delivery. An additional element may have also been that costing of this package has never really been completed. BPHS had been based on cost estimates, resulting in an often controversial figure of $4,50 per capita per annum, but it allowed a measure against which budgets could be allocated. No clear budget allocation has currently been associated with EPHS services provision. Instead, the hospital costing process is being used as a capacity-building effort.

In 2008 EPOS started testing a method to conduct step-down cost allocation of hospital services in Afghanistan. This method has been applied in several other countries and currently EPOS staff, together with key MoPH staff, are working through the various challenges to gathering all of the data related to infrastructure and equipment, personnel, drugs and medicines, recurrent budgets, and cost allocation factors for Afghan hospitals. Thus far, two non-EPHS hospitals in Herat and Kabul are being costed. Once the method is tested, it can be updated and applied it to EPHS.

The reasons why costing of hospital services has not yet been applied are varied, but often MoPH staff are unfamiliar with unit costing and its application as a building block in economic analysis of hospital services. As EPOS continues to work with the MoPH, it is hoped is that this work will become institutionalized into the Ministry, particularly in the soon-to-be established Health Economics and Financing Department (HEFD).

Ensuring quality and sustainability of hospital services in contexts of political instability by forming a hospital network

Tertiary care services for Palestinians living in Gaza and the West Bank are not available in the public sector. Instead, they have been largely contracted out to hospitals in neighbouring countries and Israel. The six non-for profit East Jerusalem Hospitals (EJH) are the only Palestinian institutions that provide tertiary specialized care for Palestinians. They operate under jurisdiction of the Israeli MoH since the annexation of East Jerusalem by Israel in 1967. East Jerusalem is the only metropolitan area accessible to Palestinians, although access is becoming increasingly limited since the construction of the Separation Wall. The EJH accounts for 578 hospital beds (12% of the total beds in the occupied Palestinian territories). EJHs provide Palestinians living in Jerusalem, the West Bank and Gaza, as well as inhabitants of Jerusalem covered by the Israeli Insurance Scheme, a combination of tertiary care, emergency and routine services and rehabilitation.

EJHs are also training institutions for pre-graduate and specialized health and medical professions training. The hospitals are therefore regularly surveyed and licensed by the Israeli MoH. Any shortcomings would mean closure. Although monitored closely, the EJH do not benefit from

investments and budget allocations granted to Israeli health service providers. Insecurity, a general policy vacuum, weak technical and managerial capacity, and a limitation in capital investments affecting the Palestinian health sector are continuously threatening the survival of these hospitals. In response, the East Jerusalem Hospital Network (EJHN) was established in 1997 to achieve cohesion and complementarity between the EJ hospitals. Areas of joint concern were identified and jointly addressed, and with technical support of the World Health Organisation (WHO), the network has been engaging in an international accreditation process that not only helps them to abide to Israeli MoH standards but also to improve the quality of care provided, to expand the scope of services and to serve more Palestinians clients.

Since the establishment of the network, the international accreditation (ISO 9001:2000) has been completed (Health InForum) and managerial standards have been established. Quality improvement was complemented by an improved capacity to treat tertiary cases (i.e. oncology, cardiovascular, ophthalmology, neurosurgery and critical care for neonates and adults) that otherwise would have been referred for treatment outside the country. This has resulted in improved efficiency and effectiveness of hospital services. The Palestinian EJH have become sustainable health institutions that are responsive to national health needs but also committed to high standards of care even under the most uncertain political conditions.

2.2 Implementation and support strategies for health services

Health systems in countries emerging from conflict are often characterised by damaged infrastructure, limited human resources, weak leadership and a proliferation of non-governmental organisations, which can result in the disrupted and fragmented delivery of health services. In this section we will explore approaches to improving access and utilisation which have been implemented in three different types of contexts: insecure settings, settings experiencing the transition from conflict to post-conflict, and more stable settings.

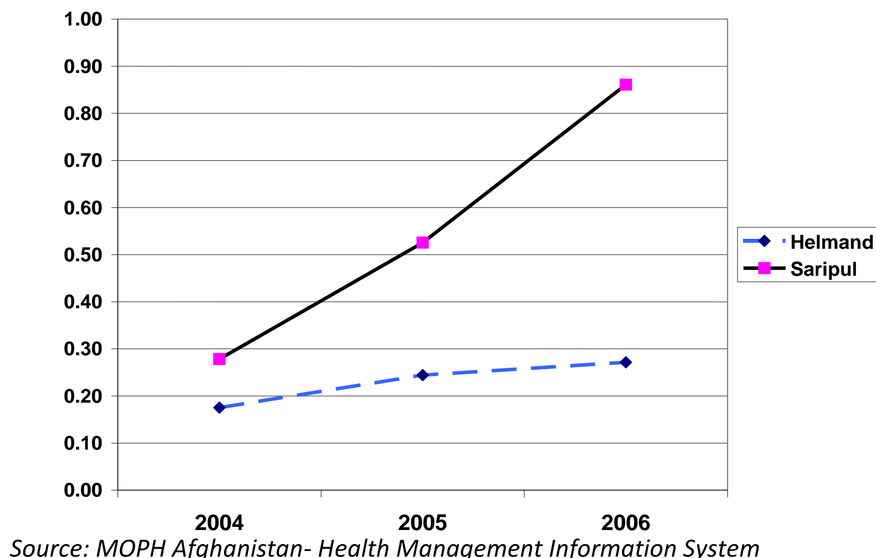
2.2.1 Improving service utilisation in insecure settings

In fragile states such as Somalia and Afghanistan, health services delivery is frequently constrained by insecurity, which not only limits access to health services by the population but also results in the reluctance of health workers to be posted in settings where their lives may be at risk. For example, in Afghanistan's Helmand Province, twelve out of 440 health workers (2.7%) were killed from 2006 to the middle of 2008. According to Health Management Information System (HMIS) reports, there had been 42 functioning facilities in 2004 but the number had gone down to 26 (a 38% reduction) in 2006. Yet against all odds, health services are still being provided in such settings. Some of the reasons for this could be that NGOs are perceived as independent of the government, they can maintain contact with anti-government elements to aid in their security, and many of the health facilities are staffed by nationals, many from the areas in which they work, which adds an element of trust and familiarity. This section explores how trust and familiarity were built in settings which were experiencing conflict, and how at least minimal levels of access and continuity of services were achieved.

Providing incentives for accessing and delivering services in insecure areas

The effect of insecurity on health service delivery is evident. The NGO (IbnSina) working in Helmand also had a performance-based partnership agreement (PPA) in Saripul province in northern Afghanistan where security has been consistently better. As Figure 1 demonstrates, the utilization of health services has grown much more quickly in Saripul, where security is better, than in Helmand. Data from other insecure provinces in Afghanistan, like Kandahar, Uruzgan, and Zabul, also indicates that these provinces are making much slower progress in health services provision than the country as a whole.

Figure 1: Out-Patient Visits per Capita per Year in Secure (Saripul) and Insecure (Helmand) Provinces – 2004 - 2006

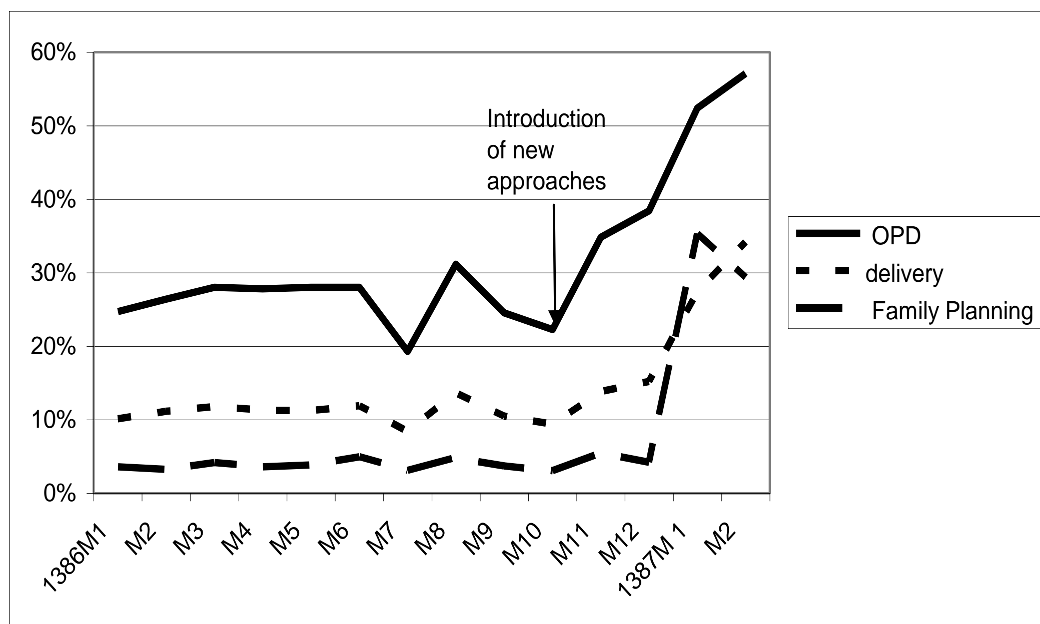


Source: MOPH Afghanistan- Health Management Information System

An added effect of the insecurity is that due to its limited capacity to implement services, IbnSina in Helmand was unable to spend its entire budget allocation. This freed up money for possible innovations in improving the utilization and coverage of the services that could be provided. Working with the MOPH and local communities, a number of new strategies were implemented, including: (i) a conditional cash transfer (CCT) scheme which provided families with cash when they brought their children for well child visits and mothers came to deliver in health facilities; (ii) a performance-based incentive scheme for CHWs that linked a payment to the number of children fully immunized, women who delivered in health facilities, and TB cases detected; (iii) a security allowance for skilled health workers on top of the National Salary Policy to keep insecure facilities well staffed; and (iv) monitoring by the provincial health office and members of the community as well as self-assessment by IbnSina.

Early evidence suggests that these innovations, particularly the CCT, are effective in insecure areas. Shortly after the introduction of the new strategies, there was a large increase in the uptake of services (see figure 2) as measured by the HMIS, which was confirmed by the provincial health department and community leaders. IbnSina staff believes that the major contributing factor to the large increase was due to the CCTs for women and children. Given that these innovations are relatively low cost and help NGOs use funds they might not otherwise be able to spend, implementing this package of innovations could make a dramatic impact on service utilization in communities affected by insecurity.

Figure 2: Changes in selected indicators after introduction of new approaches in Helmand



Source: MOPH Afghanistan- Health Management Information System. Dates are according to the Afghan calendar

Independent Service Authorities for service delivery in fragile states

Insecurity affects large parts of Somalia, making the provision of health services a considerable challenge. On behalf of Norad, the Norwegian Institute of Urban and Regional Research (NIBR) researched the viability of a concept for service delivery in Somalia called a Compact for Service Delivery (CSD) package. This package is based on a combination of three components: a Compact for Service Delivery Agreement, Independent Service Authorities (ISA), and Local Level Service Providers. A Compact for Service Delivery agreement would be an agreement between all the (warring) parties involved to allow the ISA to be set up, and subsequently be responsible for service delivery. ISAs are based on a concept developed by Paul Collier (Collier 2007):

> "In the most difficult environments it is unrealistic to imagine that traditional government social services are going to work effectively within a reasonable time horizon. It is therefore appropriate to support other channels, notably churches, NGOs, decentralization to local governments, and private enterprises. Rather than do this in an *ad hoc* fashion, it is better to think of it as a long term institution and build proper mechanisms for disbursement and evaluation of alternative channels. I term such an institution an Independent Service Authority (ISA). It can be part of government, analogous to an independent central bank, and its spending can be included in the government budget, but it would not be part of the civil service and its role would be to contract for service delivery rather than to provide it directly. Donors would fund the ISA. A key difference with the related concept of social funds is that recurrent spending would be included (Collier)".

In other words, ISAs would be authorised by a government and supported by donors on a long term basis. They would be less constrained by civil service issues and have a clear mandate for service delivery. They would be a parallel system but would be designed to be fully integrated back into government when the time is right and/or provide the basis for purchaser-provider arrangements on a more ongoing basis.

No ISAs have yet been implemented (although the Grants and Contracts Management Unit in Afghanistan described in Section 2.2.2 and the 'agence d'achat' in the DRC, described in Section 2.5.1, both show similarities). Given that their primary focus is on service delivery in fragile states, Norad decided to investigate whether such a model would be plausible in one of the most fragile of states, Somalia. The authors conclude that the ISA model may be worth considering in conflict zones, with some caveats. They suggest it should be a combination of both local and national compacts, and that the agreements should be kept simple and locally adapted. They suggest working in more stable enclaves or 'islands', although acknowledging that these can be unpredictable. A nationwide compact could be designed in which all warring parties take part. This might have spin-offs in terms of peace-building, as it would bring the warring parties together to discuss a relatively neutral topic. Service delivery agents can include commercial actors, international and local NGOs, and faith-based organizations, depending on the context and requirement for local knowledge and expertise. The scrutiny and contracting function should be done by various actors who are not in competition for service provision. In the case of Somalia, they could include clan and religious leaders as well as national and international NGOs. Overall, they conclude it may be an approach worth experimenting with in conflict-affected and other fragile states.

Approaches to service delivery in a context of armed conflict

Even though Nepal's armed conflict between 1996 and 2006 did not see the health sector targeted directly, the conflict destroyed much of supporting infrastructure such as transport, energy and communications. The deteriorating governance and the poor security situation all put increasing pressure on health services provision and utilisation, increasing the fragility of both the population and the health system (Bornemisza and Checchi 2006). The first and the second phase of the GTZ supported Health Sector Support Programme operated mainly during the armed conflict years 2001 to 2007. The organisation had to go through a strategic shift to adapt to the conflict situation. Although their primary mandate was supporting the health sector reform agenda of the Ministry of Health and Population (MoHP), the agency had to make a number of adaptations:

1. Direct service delivery: quick impact initiatives and tangible activities like construction and renovation of health infrastructures, to emphasise the health sector's role to mitigate the adverse effects of the armed conflict
2. Augmentation of the government's existing health care delivery mechanisms such as supply of medicines and equipment, support of EPI and RH programmes, the introduction of medical camps, and improving emergency response capacity in order to bring services closer to communities marred by conflict. This was done with an accent on pro-poor initiatives and vulnerable and marginalised communities, as well as the promotion of good governance
3. Operating within the Safe and Effective Development in Conflict (SEDC) framework, developed jointly with DFID Nepal, adopting a 'do-no-harm' principle and maintaining a low profile
4. Adhering to the codes of conduct stipulated by the Basic Operating Guidelines (BOG) introduced for Nepal by the UN and donor agencies (United Nations Nepal 2008)

Besides improving the quality of health services, the infrastructure support and service delivery projects had additional impacts by helping the retention of health workers in a challenging context (e.g. by doing staff quarter renovations). They also generated employment and other economic activities at a local level as most of the measures were executed by the communities themselves. By entering into a local subsidy contract with GTZ, ownership and transparency were promoted, and the communities themselves negotiated with the conflicting parties to carry on with the development work.

Joint supervision activities, where agency and government staff travelled together, allowed government staff to do supervision as GTZ had gained trust and acceptance of the conflicting parties, which mitigated any threat of abduction or demands for donation. Periodic district health performance reviews were instituted as a monitoring and planning tool to accommodate for the fact that monthly reporting was not possible. This tool has since been implemented by the government in other districts. The programme's support in the reactivation of Primary Health Care Outreach Clinics (PHC/ORC) and support of front-line health workers has also been introduced in other districts. Greater authority was delegated to regional and district level staff, for example by giving them budgetary authority for programme activities that could be implemented in close co-ordination with district health offices.

Adopting features of humanitarian aid and continuous negotiations with insurgent and counter-insurgent forces allowed the agency to gain entry to conflict-affected communities and subsequently gain access for government staff to do their work. The visible quick-impact activities resulted in increased community acceptance and support, allowing space for working on more institutional development-related activities such as strengthening governance and support of health systems. The trust and social capital gained during the conflict also supported a smoother transition during the post-conflict period.

2.2.2 Transitional service delivery models

The transition from conflict to post-conflict is complex, both in terms of creating a stable political settlement [about half of post-conflict countries go back into conflict within 5 years (Collier, Elliott et al. 2003)], and the shifting of health service provision from a humanitarian to a developmental approach. Many humanitarian NGOs choose to leave, or are forced to leave as humanitarian funding dries up. Withdrawal of humanitarian funding can lead to funding gaps for health service delivery, and result in contraction of health services. It can take years before development aid for health service provision starts to flow (Canavan, Vergeer et al. 2008). This is due, in part, to the fact that both donor and government institutions, including a Ministry of Health, need to be set-up and/or strengthened (Pavignani 2005). As governments are usually not able to take a direct service provision role, various mechanisms have been put in place to take advantage of the many NGOs, UN agencies and faith-based organizations that provided health services during the conflict. These mechanisms include contracting-out of services to non-governmental organizations (Palmer, Strong et al. 2006), capacity building initiatives by NGOs with the Ministry of Health and coordinated hand-over between NGOs and the Ministry of Health.

Contracting out of services

At the end of the Taliban regime in 2001, Afghanistan's health system was in disrepair and the country had some of the world's worst health indicators. The transitional government faced the daunting task of building a functioning health system capable of addressing the enormous burden of disease. Realizing the lack of capacity and urgent need to expand health services, the MoPH, in consultation with its international partners, made a considered decision to address this challenge by delivering a Basic Package of Health Services (BPHS) through NGOs through a contracting out mechanism, with the Ministry serving a stewardship role. All the major donors (i.e. the European Commission, the World Bank and USAID) agreed on the principles of contracting out, and on using the BPHS as the common approach in service delivery.

Contracting involves a competitive bidding process with the selection of national and international NGOs based primarily on quality and cost criteria. NGOs bid on contracts to provide BPHS services for pre-determined geographically defined areas, usually provinces. Payments, on a *per capita*

basis, are made based on achievements towards predetermined performance targets which are measured through regular monitoring by MoPH and independent third party evaluations. The ability of the MoPH to manage and oversee large numbers of NGO contracts was enhanced by the establishment of the Grants and Contracts Management Unit (GCMU) in March, 2003. Situated within the MoPH, the GCMU is responsible for technical and financial management of contracts, including finalisation of bidding documents, carrying out procurement procedures including tendering, evaluation against established criteria, and negotiations of numerous contracts. Considerable emphasis is being placed on independent monitoring and evaluation of the implementation of the contracts. MOPH, with technical assistance from the Johns Hopkins University and Indian Institute of Health Management Research, has adopted the Balanced Scorecard (BSC) as a tool to measure and manage performance in delivery of BPHS throughout Afghanistan.

Afghanistan is the first country that has adopted contracting out on a national scale. Contracts currently cover 31 out of 34 provinces and 85% of the population. Evaluations indicate considerable improvements in services provision and quality of care:

- An increase in the number of functioning health facilities from 496 in 2002 to 1460 in 2008.
- A decrease in Infant Mortality Rate (IMR) from 165 per 1000 live births in 2000 to 129 in 2006.
- A decrease in under 5 mortality from 257 per 1000 live births in 2000 to 199 in 2006.
- An increase in the percentage of facilities with skilled female health workers from 24.8% in 2002 to more than 80% in 2008
- An increase in use of skilled birth attendants from 6% in 2003 to 18.9 % in 2006.
- An increase in DPT 3 coverage from 31% in 2000 to 80% in 2008.
- An increase in Measles vaccine coverage from 35% in 2000 to 74% in 2008.
- An increase in TB case detection rate from 10% in 2001 to 70 % in 2008.

Services were rapidly scaled up as NGOs were able to harness their local expertise and capacity in health services provision and were not hindered by internal bureaucracy to the extent the government would have been. And with NGOs responsible for the scaling up of services, MoPH was able to focus on policy development and monitoring of services as they were implemented.

Private-to-public transition model

Health services provision in Southern Sudan moved from “crisis” into “transition” with the establishment of a Ministry of Health in January 2006. As there was no functional state government during the civil war, soon after transition it was estimated that 86% of primary health care facilities were being run by NGOs. During the NGO health forum at the first Southern Sudan Health Assembly in 2007, NGOs described a need to change from their traditional role of direct service provision with little coordination, to a more structured one, working alongside the MoH Government of Southern Sudan (GOSS) in implementing health care and supporting it at all levels to strengthen the health system.

Analysis highlighted the existence of good relations and coordination between health stakeholders, the need to overcome significant infrastructural and human resources constraints, the opportunity to start a new health system using experience from similar contexts, and a possible transitional funding gap. The key question raised was how the ‘relief’ NGOs working in Southern Sudan could respond to the transition. A number of options were put forward:

1. Continue implementation of health care provision at the community level
2. Migrate to health systems strengthening, building up the capacity of both local and national health systems to enable them to manage the health facilities in the long run

3. Combinations of status quo and option 2
4. Capacity building of local partners (i.e. religious and civil-society organisations) to enable them to manage local health services
5. Empowering communities to be responsible for their local health services
6. Handing over of health facilities to 'development' organisations

Each of these approaches had benefits and disadvantages, required varying time frames for implementation, and some options were simply not possible in specific areas due to, for example, a lack of local partners or 'development' organisations. A strategy has now been proposed that addresses support at all levels (central, state, county, and local). The proposed approach is phased, to facilitate a smooth transition. Time frames are not fixed as local contexts differ in terms of human resources and infrastructure capacity. Phases are, rather, defined by the achievement of specific indicators, and can be adapted as needed. It is also recognised that at times transition may have been made too rapidly or external circumstances may have changed, and processes may need to be moved back one phase again. The proposed phases have been named as follows:

1. NGO delivery of health services
2. NGO direct implementation of health services on behalf of the MoH, whilst HSS takes place:
    a. NGO continues to develop local community support structures
    b. NGO builds up capacity of the County Health Department (CHD)
    c. NGO assists MoH GOSS at state level
    d. NGO works closely with MoH GOSS at central level
3. MoH GOSS directly implements health care on behalf of the population, while NGOs continue to support HSS activities.
4. MoH GOSS independently coordinates and delivers all health services

Risks and assumptions have been outlined for this process, and ideas on how to mitigate against the identified risks have been put forward, but the ultimate goal of the proposed transitional process is to allow for an independently functioning MoH that can request assistance from partners if the circumstances require.

NGOs working alongside the MoH towards HSS

The model described above has been developed to guide the process of transition, which has as the ultimate outcome an independent MoH. Looking at this process from the viewpoint of a 'relief' NGO, the outcome of interest is somewhat different, namely how to ensure that the agency can 'exit', while ensuring health services provision is not interrupted. This means NGOs have to switch focus from the traditional service delivery approach to a HSS approach. HSS can be new territory for many 'relief' NGOs and requires a new approach and ways of thinking. In Upper Nile State, Southern Sudan, which could be taken as Phase 2 as described in the previous section, stakeholders are adopting three key approaches to assist with this transition:

1. Donor policy has started to focus on empowering the State MoH to take greater leadership in health services delivery by focusing on capacity building at the State level, (e.g. DFID funding for drug supply and management and health services planning), and by ensuring State leadership of the Health Multi-Donor Trust Fund (MDTF).
2. NGOs such as Medair and Tearfund are focusing on development of County Health Departments (CHDs) through various processes, including informal skills and knowledge transfer, formal capacity building of CHD staff, peer learning workshops between neighbouring CHDs, development of a baseline CHD assessment tool [adapted from (Management Sciences for Health 2005) and (Tearfund 2003)], promoting accountability

towards MoH through public MoU signing ceremonies, and the introduction of a monitoring tool (Petrie 2007) for NGOs to measure development of institutional sustainability. NGOs are advocating at both state and central level for the inclusion of health staff on the MoH payroll.

3. Development of a donor-supported 'exit strategy' and transition timetable. The the Basic Services Fund's (BSF) requirement for NGOs to develop an exit strategy acted as a driver for NGOs to begin seriously planning a handover with the MoH/CHD/communities. The current timeframe of 2 years is likely to prove unrealistic, however, and a milestone approach to phase length may be required. Medair have looked for greater alignment with existing MoH services and structures, such as adjusting drug supply mechanisms. Tearfund have appointed a technical advisor to lead the mainstreaming of an HSS approach into the agency's programme strategy.

These approaches are still relatively recent in terms of the post-conflict recovery process in Southern Sudan. However, there are some encouraging signs that a more coordinated and MoH-led approach to HSS within the state may start to pay dividends. The MoH has formally appointed CHDs and has relocated MoH staff to support them. Staff allocations have also been readjusted to fit the GOSS equivalent of the Basic Package of Health Services (BPHS). Inception phase MDTF funding through lead agent IMA World Health coordinated within the SMoH has encouraged a closer working relationship with partner NGOs. The BSF's policy on the promotion of exit strategies has promoted greater ownership and leadership at local levels for handover. In some counties, communities and local health authorities are showing signs of higher expectations of the MoH and other health institutions, indicating that greater accountability is being developed. Partnerships between NGOs in the State in developing areas of good practice for CHD development has been effective at a time when the evidence base and MoH policy centrally is still developing. Further challenges and opportunities remain to be addressed in this process, but key lessons learned are included in Box 4, below.

Box 4 - Transferable Lessons learned during the transition phase

For governments

- State level coordination of funding is an effective way of developing MoH leadership
- Encouraging harmonisation between NGOs within States makes MoH partnerships more coherent and effective
- Systems cannot be developed in isolation by NGOs, they need to be built and coordinated at county, state and central levels

For donors

- Donor influence (e.g. requirement for NGO exit strategy) and funding mechanisms (e.g. which require MoH leadership) can successfully act as a promoter of transition to enable HSS, as well as donor advocacy on issues such as MoH paying health staff salaries.
- Learning between organisations through peer review, as promoted by the BSF, is a very cost effective way of sharing best practice between organizations/with the MoH
- Partnership working between NGOs is required for a coherent system in a county/district

For NGOs

- County Health Department/District Health Authority development can only be developed through a MoH led process e.g. staff appointments etc. This needs to happen early in the post conflict recovery phase if transitions are to be successful.
- Pragmatic tools/techniques such as peer learning workshops, CHD baseline assessment and BISAC monitoring tool (Petrie 2007) can enable NGOs to be more effective in HSS.
- HSS is a cross-cutting theme which needs to be mainstreamed into NGO programmes supporting service delivery. It cannot work in isolation.

2.2.3 Strengthening service delivery and improving utilisation in more stable settings

In fragile states more generally, many health sector reforms are aimed at strengthening service delivery to improve accessibility, coverage, and utilization, especially by the poorest. Many of the examples below come from more stable settings where certain reforms, such as decentralization, may be more viable. Included below are examples of decentralisation, performance-based financing and voucher schemes.

Decentralisation

In Nigeria, PATHS supported a number of states to address the difficulties with fragmentation and overlap in service provision between the public and private sector, staff and supply shortages in the public sector, poor referral systems and multiple management structures co-existing between different levels of government. The emphasis of the programme was on the development of an integrated and decentralised health system as one of the cornerstones of the reform strategy (Enyimayew and Mckenzie 2008). The programme supported the evolution of three models:

- The essential healthcare package model in Ekiti State - a service-driven model that started with the delivery of an essential healthcare package as the entry point
- The District Health System in Enugu State – an institutional restructuring and management strengthening model that had support from the state Governor
- The Gunduma Health System in Jigawa State – a similar model to Enugu but where state-health managers were re-orientated to become change agents for the district health system model.

The key issue in the programme was not whether one model was better than the other, but rather whether each model was robust enough to address the structural weaknesses in the health system. Although developing integrated health systems for an entire state (with the associated legislation, and institutional restructuring) is nothing short of a major health sector reform initiative (evidence from other countries suggests that a decade or more is needed for such reforms to have the desired impact), and it is too early to expect significant results from the new models piloted in Nigeria, early evidence suggests that the integrated health systems are starting to deal with some of the existing health sector problems. Jigawa and Enugu both invested time and effort to ensure the necessary legislation was in place to support the integrated health systems, and the models in these states have a better chance of being sustained than those that did not. Those states that invested very significantly in developing political support and local ownership have demonstrated even greater possibilities of being sustained. In Jigawa a long process of engagement has resulted in greater local ownership with high political support and has yielded significant structural and institutional changes.

A number of lessons were learned in the project period. One was that the basic model of the WHO District Health System (based on the key principles of improving integration, decentralisation, co-ordination, access and effective health services) can be adapted to suit state-specific situations. Nevertheless, although health services problems were similar across states, there is no one-size-fits-all model of an integrated health system for a country of great diversity and with a federal form of government that provides for local initiative to deal with local problems. Exposure to successful examples early in the process of health sector reform, (done here by visiting Ghana in early 2007) is essential to building a critical mass of converts to carry the process of change forward, and for convincing opponents and the undecided of its feasibility. Finally, formal legislation to back the existence of a decentralised health system provides an essential environment for sustained implementation of reform efforts by local managers.

Voucher schemes targeting populations at risk

Nicaragua experienced several episodes of civil war between 1970 and 1990. Five years after the election of a new government in 1990, which started cutting back severely on what was described as a communist style health care system, a competitive voucher scheme was introduced in order to ensure that targeted health services could be delivered to vulnerable populations. Competitive vouchers are one of many demand-side financing approaches, linking public funding to delivery of healthcare. The Central American Health Institute (ICAS) implements and manages the Nicaraguan voucher programme which targets (1) populations at-risk for HIV such as sex-workers and drug-addicts with STI and HIV/AIDS services (1995-ongoing), and (2) poor adolescents with sexual and reproductive health services (2000-2005). ICAS acts as the voucher agency. It contracts clinics (public, NGO and private sector), organises training, defines service packages, analyses data, and monitors quality. ICAS staff and, when possible, community-based organizations, regularly distribute vouchers and health educational materials to all members of targeted populations at prostitution sites, markets, poor barrios, public schools, etc. The vouchers entitle the bearer to a package of 'best practice' services free of charge at any one of the over 50 contracted clinics. Clinics compete for contracts on the basis of price, quality, and location, and are reimbursed at a fixed fee per voucher. Two impact evaluations were carried out – quasi-experimental intervention study in 2000/2001 and prospective cohort study 1995-2005.

Between 1995 and mid 2008 almost 150,000 vouchers were distributed and 37,216 medical consultations provided: 22,082 to populations at-risk and 15,134 to adolescents. Vouchers were used according to need: uptake among populations at-risk was 33% (female sex-workers 45%, male populations at-risk 33%), and 20% for adolescents (female 25%, male 13%). The cohort study showed a considerable reduction of STIs in female sex-workers from 1996 to 2005 (syphilis 9% to 3%, trichomonas 16% to 8%, both $p<0.00001$), while HIV prevalence remained <5%. Unplanned variations in the time between STI treatments (due to irregular funding) allowed attribution of overall STI reduction to the program. The quasi-experimental study showed female adolescent voucher receivers to have a higher use of services compared with non-receivers (OR 3.1, CI 2.5–3.8). At schools, sexually active receivers had a higher use of contraceptives than non-receivers (OR 2.3, CI 1.2–4.4); in neighborhoods, condom use was greater among voucher receivers than non-receivers (OR 2.5, CI 1.4–4.5).

Vouchers increase access to priority services and have an impact on the health status of populations who are currently underserved. Vouchers encourage the use of services because they remove financial barriers, provide information, guide potential users to the services, and guarantee proper treatment. Vouchers empower clients by allowing them to use the voucher at the clinic of their choice, providing incentives for clinics to be innovative, cost effective, and responsive to clients. Although they may be challenging to implement in rural areas of fragile states due to the lack of adequate health services, voucher schemes may be an innovative way of ensuring that the poor and/or high-risk populations in larger cities have access to essential services.

2.3 Leadership and governance: roles of the key stakeholders

Leadership is the most complex but also crucial component of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. Both political and technical expertise is required to address competing demands for limited resources, but there is no blueprint or single, fixed approach for effective health leadership and governance. Key components include policy guidance, information and oversight, collaboration and coalition building, regulation, system design, and accountability (WHO 2007).

Weak leadership and poor governance are some of the defining characteristics of fragile states; health sector policies in these contexts are frequently ill-defined, while regulation and oversight in a powerless and possibly corrupt system are not very effective. What roles, rules and practices should be established to build the public's confidence and trust in the ability of the reconstituted Ministry of Health and other social welfare institutions to respond fairly and equitably to people's health service requirements? And how should this be done? An increasing range of instruments and institutions have been developed to strengthen effective leadership, management and governance (Waddington, Egger et al. 2007; Brinkerhoff and Bossert 2008). These include mechanisms that work to strengthen leadership within the government, the NGO sector, and the private sector.

2.3.1 The government

In a post-conflict setting with a diversity of national and international demands, the demand for rapidly (re)expanding social services and achieving set health targets needs to be balanced with requests for improved governance and public administration reforms. Delivering high quality, affordable and sustainable health services requires a strong health system which is capable of addressing challenges in service delivery and providing 'good governance' through, for example, ensuring accountability and responsiveness to the people. Government leadership is needed on key components such as financing, management and the health workforce, infrastructure, medical supplies, and information systems. Internationally, evidence shows that investing in institutional capacity development in fragile states supports governments to perform leadership and core governance functions, which in turn sustain the systems needed for better services and contributes to increased credibility and stability.

In the (early) reconstruction phase, ministries of health are generally assisted with the development of (sector) policies and medium-term expenditure frameworks for an equitable standardized package of care in order to ensure the best possible results according to available resources. However, as the examples below will demonstrate, a strong local leadership that is able to properly harness the available resources and provide coordination and guidance for collaborative processes are key to ensuring the survival or successful rebuilding of a health system.

Leadership and the need for developing institutional capacity

Since the establishment of a new national government in 2002, the Afghan MoPH has tackled challenges in areas critical to institutional development - and to building an effective health system - such as human resources management and development, public health management and administration, planning and budgeting, and the delegation of authority to provincial health teams. Partners have recognized that developing the MoPH as an institution means to strengthen the stewardship role it has adopted and exercised, and to lay the foundation for a 'good governance' framework. To achieve this, the implementation of a coherent, long term and balanced approach to developing the MoPH as an institution has been envisioned in the Afghanistan National Development Strategy (ANDS). This should better balance the achievement of rapid gains in basic services against necessary long-term investments in institutional capacity in order to build a strong health system, maintain achievements, and ensure government ownership.

In recent years the MoPH, working with development partners and non-state providers, has been leading a number of critical processes for contributing to stability and social development of Afghanistan, including: 1) bringing health services to poor and rural people; 2) moving public administration reform forward with elements of good governance such as transparency and accountability; and 3) demonstrating stewardship by clearly providing technical guidance, regulating and monitoring the health system and formulating policies and strategies. Challenged by the largely dysfunctional health system, the strategy for contracting out service delivery

(described in Section 2.2.2) has rapidly expanded the geographic scope of the BPHS to meet the health needs of its population, especially addressing rural areas and the needs of women and children. As a result, there have been major gains in some key health indicators such as reduced infant and child mortality.

With appropriate external support, MoPH Afghanistan has a unique opportunity to demonstrate how building capacity for good governance, including strengthening management and administration functions, can contribute to sustainable improvements in health service outputs and outcomes in public and non-state sectors.

Effective management and leadership during a period of crisis

Timor-Leste faced a significant national crisis in 2006 when internal conflict led to near-complete collapse of governance and service provision, and internal displacement of a high proportion of the community in Dili, the capital city. Most government ministries collapsed and ceased functioning, in some cases for months. The Ministry of Health (MoH), however, continued to function, providing services and coordinating local and international engagement in the humanitarian and services response. They faced a number of key challenges. These included a) maintaining service delivery and reassuring the community that health care would continue to be available through state services; b) coordinating humanitarian and development actors from within and outside the country; c) maintaining a balance between immediate crisis response activities and the longer-term development actions that had already been planned by the MoH; and d) ensuring that health workers did not get drawn into the internal ethnic conflict. Confronting these challenges involved both close coordination with other key stakeholders as well as addressing issues internally by showing decisive leadership coupled with a certain measure of flexibility.

The MoH worked with key non-state actors in order to ensure that services continued to function in both government clinics and in specifically established health services for the large number of IDP camps in Dili and its vicinity. A key element of this response was establishing a close liaison with the Cuban Medical Brigade which was stationed across all the Districts of Timor-Leste, and drawing them in to Dili to provide services in the hospitals, government clinics, and IDP camps. A wide range of other NGOs also worked with the MoH to ensure services continued to be offered despite the crisis. To ensure that services were delivered in a coordinated manner, the MoH established a health coordination structure which brought together all the health-related actors for regular briefings and discussions. A number of working groups were established and key NGOs, UN agencies, military and other service providers, worked under the leadership and coordination structures set up by the MoH. With the support of their development partners, the MoH was also able to maintain a balance between immediate crisis response activities and longer-term development by taking steps to ensure that the specific interventions developed during the crisis period were wound down as soon as possible. This ensured the sustainability of services provision and facilitated a return to the planned activities being developed and implemented by the Ministry of Health.

A key challenge was to ensure that health workers did not get drawn into the internal ethnic conflict. In order to address this, the Minister of Health led by example and publicly declared that the MoH was neutral and that all health workers were expected to perform their duties in response to community need. The Minister, working with his senior management team and liaising regularly with hospital and district managers, encouraged the MoH staff to serve the community. He drew attention to the ethical basis of medicine, the values underpinning the MoH (i.e. service, ethics, solidarity, equity), and indicated that health workers who took sides would be disciplined.

In addition to addressing the four key challenges, a number of other adaptations during the crisis period also allowed activities to continue. Health workers who were displaced were able to continue on the payroll by offering their services at another site which was perceived to be more secure. Dili based hospital staff who had lost their homes were offered accommodation within the National Hospital grounds. Cash was made available to a senior health manager to ensure that funds were readily available for needed activities and supplies even when central services had shut down. NGOs worked with MoH personnel to fill gaps in logistics and supplies availability.

2.3.2 The NGO sector

NGOs that have been providing humanitarian relief during the crisis represent both a challenge and an opportunity. Those with a strictly humanitarian mandate usually depart the country post-conflict, sometimes leaving the populations they have been serving without access to services as there is no funding available, and/or there is no partner to hand-over to; this can result in a decrease of health services at the national level. Those with a more developmental mandate often transition from providing humanitarian assistance to supporting a central government. During this time, they often continue to provide services, in particular of primary health care (High Level Forum on the Health MDGs 2005).

The role of NGOs in transition

It is recognised that providing health and other key social services as part of humanitarian emergency response and post-conflict interventions is important, especially in the context of epidemiological crises (Checchi, Gayer et al. 2007), restoring state functioning, and contributing to reducing the sources of fragility such as social exclusion, low state legitimacy, and weak state effectiveness (Brinkerhoff 2007). One of the key challenges faced by institutions in a post-conflict environment is determining *how* to make the transition from emergency assistance and relief to strengthening the health system for the long term. Non-Governmental Organizations (NGOs) can play a key role in helping fragile states to rehabilitate their health systems. However, transition strategies and interventions, and with these the roles that NGOs can play, need to be contextualized for particular country situations, as summarised below (Brinkerhoff 2008).

Post-conflict assistance can be divided up into three phases: (1) responding to immediate health needs, (2) restoring essential health services and (3) rehabilitating the health system. These three phases encompass a scale of interventions which range from humanitarian relief, in which NGOs play a key role, to sustainable development, in which government leadership is of the essence. The trick for effective transition strategies is to build activities during the relief phase which can serve to create a foundation for longer-term health system strengthening. NGOs need to keep in mind that transitional programming can already start during the conflict and immediate post-conflict phase. In their programming they should take into account the need for the state and the public health system to build legitimacy among its citizens by being seen to deliver goods and services, as well as the need to rebuild or create sustainable public health system capacity, including in financing, operations and governance.

Donors play a crucial role in facilitating this process. They need to constructively align their relief assistance with the country's public health agencies so that (1) existing sources of capacity and political will can be identified and capitalised on, (2) relief activities can be structured not as stand-alone efforts but rather as components of an eventual hand-off to country actors, and (3) service-provider contracts are structured to create incentives for transitioning service-delivery operations from international NGOs and firms towards building local capacity and engaging with public health system actors. NGOs and donors can support transition from relief to health system strengthening in fragile states by including capacity building activities for health officials and approaches to

minimise transitional services gaps into every stage of the planning cycle for programme implementation.

Supporting the government in providing primary health care services

Partially as a result of targeted funding available to NGOs, partially due to government bureaucracy, and partially due a collapse in infrastructure, health services provided by NGOs in fragile states often operate in parallel of government health systems, which often leads to a further weakening of the health system over the long term. Health Alliance International (HAI) works in four countries that are emerging or have recently emerged from conflict: Mozambique, Timor-Leste, Côte d'Ivoire, and Sudan. Starting in 1987 in Mozambique, HAI developed a model of close partnerships with Ministries of Health (MoH) to improve and expand health services through the government health systems. It provides MoH staff at all levels (national, provincial, district) with technical support including management and clinical training in health care, follow up coaching and support of trainees, troubleshooting, monitoring and evaluation (M&E), and operations research. HAI also often commits resources to government infrastructure priorities, such as the construction or rehabilitation of health facilities and laboratories, and development of data management systems that are ultimately owned and operated by the MoH itself.

This collaborative effort contributes to the important goal of supporting national stability during times of crisis and post-crisis rebuilding. It allows a sharing of expertise for the benefit of the country as a whole. Key factors in this collaboration are flexibility in the NGO's work plans, responsiveness by MoH leadership to innovative contributions, and regular ongoing communication between MoH and NGO staff at all levels. In Timor-Leste, where HAI has been working since 1999, one of the national priorities of the MoH is maternal/newborn care and child spacing. Working with the Ministry, HAI staff conducted an assessment in two districts of the needs of pregnant women and the prevailing knowledge, attitudes and beliefs about childbirth. The assessment revealed that an important reason for the low rate of delivery in a health facility was the facilities' lack of accommodation for key cultural practices during childbirth. In partnership with the MoH and with community input, agency staff designed an innovative "birth-friendly facility" and built two pilot facilities, staffed by government health workers. Following positive evaluations an additional four of these facilities are under development. This example demonstrates that in fragile states, especially in contexts where resources are often limited, NGOs can make a valuable contribution to sustainable and innovative health services delivery by supporting and/or collaborating with the local MoH.

Coordinating the planning of activities through the MoH

Ministries of Health in fragile states can face considerable challenges in tracking the activities of multiple NGOs. Sometimes hundreds of organizations exist that operate independently, each with different goals, reporting requirements, time frames and sources of funding. In order to strengthen the managerial capacity of often weak health systems, NGOs reduce the management burden and strengthen local capacity by engaging in planning with ministries to ensure that NGO goals, activities, reporting and timing align with government plans and priorities. In a number of countries, HAI works closely with MoH staff in a shared planning process which allows the NGO to focuses its resources and activities on areas in which the MoH requires additional support. Some mechanisms that support such an approach include sharing office space within the MoH, ensuring daily contact, and regularly exchanging ideas with Ministry partners and other NGOs in targeted coordination meetings. Although collaboration with government partners can be more time-consuming than independent planning and action by NGOs, the result is a more coordinated approach that benefits the public sector health system as a whole.

The coordinated planning approach is further strengthened by common or basket funding approaches, as was implemented by the government of Mozambique in 2003. Through this mechanism, donors such as the Global Fund for AIDS, Tuberculosis and Malaria provide the majority of their health sector support to a central MoH fund and support coordinated planning activities.

Partnerships between national and international NGOs for services provision

There is currently considerable enthusiasm for the approach of contracting-out of health services in post-conflict countries, and for the promotion of national NGOs in this process. The experience in Afghanistan is seen as a model in this respect. The roll-out of the Basic Package of Health Services (BPHS) in Afghanistan involved (in part due to encouragement from donors) the collaboration of international NGOs with national counterparts in bidding for and implementing the service contracts awarded by the Ministry of Public Health. In a review that Merlin conducted on the impact of the national/international NGO partnerships on BPHS services provision in Afghanistan in early 2008, it was found that International NGOs reported a range of potential risks in partnering with national NGOs, including the lack of senior management capacity, nepotism, lack of transparent and consistent standards, and weak governance. On the other hand, national NGOs reported a lack of consultation between international NGOs and their national partners, a regular turnover of expatriate staff, disrupting relation/trust building processes, and the perception of national NGOs as the junior partner (often manifesting as a lack of respect for colleagues on the national side of the partnership). A number of these opportunities and challenges were also reflected in the partnership between Care of Afghan Families (CAF, a national NGO), and Merlin (an international NGO) who had, both individually and jointly, bid for and implemented programmes since 2003.

At the time of the review the partnership between Merlin and CAF had been through a number of phases which had resulted in a progressive integration of activities and a deepening of the partnership over time. These phases included an initial partnership in Takhar Province where the programme was designed by Merlin and a section of the programme was sub-contracted to CAF. This was followed by a second phase in Badakhshan province where both organisations jointly developed the programme design and divided activities between agencies but maintained separate offices and staff, and a third phase in Kunduz province where the programme was based on a joint programme design but also a shared office and use of the name “Merlin-CAF/CAF-Merlin” in employment contracts, e-mail address and donor reports. At times the partnership had been considered very strong and a “model of good practice”, while at other times it required support from outside the partnership to resolve issues.

The review found that there was no doubt that the partnership had provided opportunities on both sides which would otherwise not have been available, such as access to funding (when partnerships between NGOs was a requirement) as well as individual access to key stakeholders, such as CAF’s strong community links and Merlin’s international links. It was important for the partnership that both partners had a strong capacity for implementation of service delivery from the onset, and that CAF had the ability to rapidly scale up. It was found that a number of important factors helped support the implementation and development of the successful partnership over time, including getting to know the partner organisation’s internal procedures and working practices, and taking time to negotiate an MOU for the partnership which was separate from the programme design and outlined the degree of integration of project identity, resources and offices as the partnership matures with the aim to reduce costs and increase efficiency. Vital to the success of the partnership was the commitment by senior staff from both organisations at the onset and throughout the partnership, and building mutual respect and

understanding whilst recognising and accepting that that each partner may wish for something different from the partnership.

The Merlin-CAF partnership presented a number of positive outcomes both within and outside the partnership but it also showed that it required considerable effort on both sides to ensure that the partnership worked well, and that the development of the partnership was not instantaneous, but rather a process over time. As contracting out of services is currently being considered for other contexts, and a partnership arrangement between International and national NGO is also proposed, it is important to remember that the level of capacity within national NGOs in Afghanistan was high at the time of the contracting model roll-out, relative to other fragile states. In countries where the national NGO sector is not as well developed or resourced, the partnership model may prove difficult to implement. It will be important to set realistic expectations for the partnerships in terms of the inputs required, progress over time and expected outcomes for both partners.

2.3.3 The private sector

The public sector, even if willing, is not always able to provide essential services to all of the population. In some cases, public health facilities are simply too busy, too far away, or lacking essential staff and medications. In other cases there may be financial, cultural or political reasons that limit the public sector's capacity to implement certain services. One alternative is for the population to access essential services through the private sector, which, although possibly more expensive, may have the required services available. In fragile states, the private sector is generally poorly regulated, if at all, even though it is frequently the primary provider of health services and medical supplies in these contexts. As a result, it is often thought that the private sector can do more harm than good, and investing in the private sector diverts key funding away from the private sector. But as the examples below illustrate, collaborations between the public and private sector can also contribute to improving the quality as well as the quantity of health services available to a population, with a potential impact on population morbidity and mortality that may otherwise not be achieved. Additionally, public-private partnerships can lead to improved supply systems, as is illustrated by an example in Section 2.6.2, and partnerships between private sector parties can improve accessibility to health services that are essential but do not directly contribute to the reduction of morbidity and mortality, such as the example of eye care in Section 2.4.2.

Provision of family planning services through the private sector

Yemen is the poorest country in the Arab World, with few resources and high levels of unemployment. A recent briefing report by the Royal Institute of International Affairs cites rapid population growth as a key contributing factor to Yemen's status as a fragile state and an issue which must be addressed to prevent further decline (Hill November 2008). According to the Population Reference Bureau, the total fertility rate is 6.2 and 45% of the population are under 15 years old. Without interventions, including the education of women and ensuring the availability of family planning choices, the population is projected to grow by 151% before 2050. The Yemeni government has introduced a number of policies aimed at ensuring the education of the girl child and improving health services throughout the country. However, progress has been slow and there has been a deterioration of public services in recent years.

Marie Stopes International (MSI) has been providing reproductive health services in Yemen since 1998. In 2006, an innovative social marketing project, funded by KfW (the German Development Bank), was started in partnership with the government and private sector to distribute good

quality contraceptives at subsidised prices through private clinics and pharmacies. This approach was reinforced by the findings of a baseline study, which found that pharmacies are the second most common source of contraceptives, after government clinics. In addition to training doctors, midwives and pharmacists in all aspects of family planning provision, including counselling, the project also includes training in procurement and project management for ministry staff, while retailers have benefited from training in advanced selling techniques.

Through a large private pharmaceutical distribution company, contraceptives are available in over 3,000 outlets, including clinics and pharmacies, making quality contraceptives available at affordable prices for many, even in rural areas. However, reaching the poorest of the poor remains a challenge. Another challenge is the lack of coordination and cooperation between the government and the private sector, despite the fact that many service providers work in both sectors. However, professional bodies, such as National Association of Pharmacists are working to bridge this gap. Although the impact of this approach may not be immediately measurable at population level, the provision of contraceptives through social marketing in Yemen provides a good example of how private initiatives can successfully contribute to improving access to key services in fragile states.

Social marketing of treatment and preventive measures

In fragile states there is often a lack of health infrastructure to provide health services to much of the population. Within this context, non-state structures often play a valuable role in extending basic health services, although there is little quality control and these services may often be of doubtful quality. Social marketing provides an opportunity to expand access to basic health products and health messages to those who are not able to readily access healthcare, and ensures that life-saving products and services are widely available through existing commercial and civil society channels, reaching both traditional and non-traditional outlets such as kiosks and market stalls. The complementary health communications and training programmes educate vendors about the products being sold and promote the adoption of healthy behaviours to at-risk populations.

Population Services International (PSI) has established health platforms in countries like Angola, Zimbabwe, Somaliland and South Sudan which address multiple health needs (i.e. reproductive health, malaria prevention/treatment, diarrhoeal disease prevention/treatment, HIV/AIDS prevention) through integrated social marketing programs to improve the health of low-income and other vulnerable people. Marketing principles are employed to *inform* and *ensure availability* and *access* to needed health messages and products. For example, the promotion of household water treatment works by:

1) Influencing behaviours of individuals to take immediate action to improve their water quality through affordable options available in the market.
2) Leveraging the local commercial sector to participate in the delivery of life-saving health products.
3) Maintaining a balance between affordability to target groups and financial incentives which drive the commercial sector.
4) Creating and sustaining demand for household water treatment among target groups through evidence-based social marketing campaigns.
5) Developing synergies between commercial sector provision and national marketing campaigns and public sector and community-based initiatives to improve household water treatment and hygiene behaviors.

Working in Zimbabwe since 1996, PSI provided a range of health services, products and messages in HIV/AIDS prevention and counselling, family planning and child survival. Through Measuring Access and Performance (MAP) studies, social marketing performance among vulnerable populations was measured at the individual level as well as by assessing the delivery systems through which these populations are reached. A MAP study on condom coverage in 2006 concluded that the coverage of public sector condoms was low across all districts in Zimbabwe. This suggested that little overlap, and thus little competition existed between the public sector and socially marketed condoms. Estimates were also made with regards to the additional coverage provided through private sector channels to promote HIV/AIDS prevention. In Bulawayo, more than 95% of outlets had at least 50% coverage, while for public sector this was only 30%. For Harare, more than 95% of outlets had at least 50% market penetration but only 45% of the public sector outlets met the same coverage. The discrepancy in coverage in Mashonaland was even higher: 37% private sector coverage and 6.1% public sector coverage. Working in over 60 countries, PSI's 2007 figures indicate that through its social marketing programs millions of condoms were sold, with roughly 25,000 patients purchasing treatment for TB and 19 million for malaria. This significantly contributes to the prevention of HIV infections and unintended pregnancies, as well as to a reduction of deaths from malaria and diarrhoea.

2.3.4 The community

Communities are not only the clients of health programmes, but also partners in the development process. Ideally, communities should be co-owners of health services programmes, contributing to all elements of the planning cycle, from assessment to evaluation of services. But especially in the context of fragile states, caution must be exercised not to demand more from the communities than they are able to offer. In many cases, a sincere effort is made to include the strengthening of community voice and accountability in a programme's main objectives, as described in a number of examples provided in different sections of this paper. However, in a worrying number of cases communities have also been used as sources of free labour or revenue to address shortfalls in programme budgets. These deficiencies could either be a genuine product of insufficient funding available, but in a number of cases, corruption has also played a role. Voluntary contributions of time and money make sense in a context where communities are not struggling to feed themselves, but in the context of fragile states, demands put on communities, even by simply charging user fees for health services, could mean that some people may have to make the choice between their own survival and contributing to the greater good of the community (Poletti 2004).

Community Participation

Experiences from Zabul and Uruzgan, two of the most insecure provinces in Afghanistan, prove that there was no fluid continuum between conflict, post-conflict, peace, or whatever gray zone in between. Rather, it was back and forth with a high degree of unpredictability. Even in these most adverse circumstances, a three-pronged approach of community participation, capacity building and strengthening health systems proved to be the most solid basis for development.

Community involvement in these insecure areas was achieved by creating 'community trust'. Both IbnSina and Afghan Health and Development Service (AHDS), the two NGOs responsible for implementing BPHS in Uruzgan and Zabul, established close contacts with community representatives during the start-up phase. The communities were involved in initial needs assessments. The community and religious leaders were instrumental in securing land for the construction of new health facilities and, in some cases, convincing medical personnel to return to their home towns to work in the new health facilities. Without the protection of local community leaders it would be impossible to start up any health services in the more remote areas. Some of the mechanisms that aided this building up of trust included establishing community health

committees or ‘shura’ in all districts of operations, both male and female shuras. In addition to planning of health activities and enhancing community trust and participation, these committees were also responsible for the selection of the Community Health Workers (CHWs) that were to serve their communities. After the CHWs had been trained and equipped, community health committees met regularly with their CHWs to share local problems and provide feedback on the quality of services. The health posts, staffed by CHWs, were often the only way that communities in more remote areas could access any form of health services.

In places where health centres were started, communities also were able to offer security to some extent, but only within the towns and villages; they were not able to control the roads, and travel was dangerous. Therefore, expansion of formal health services was very slow and tedious process, sometimes frustrating communities that made so many efforts to facilitate start-up of health services. For many years community and religious leaders were able to negotiate informal cease fires between government and insurgents to allow unharmed passage of vaccination campaign teams. As a result of this, vaccination coverage reached higher levels than expected in insecure areas.

Health workers’ respect for the local culture and traditions was crucial. At recruitment, all new health facility staff were explained how to follow medical ethics, how to show they were politically neutral, and how to build trust. Community trust also led to a slow acceptance by communities to have male staff provide services to female patients, and allow females to be trained as CHWs, as female staff recruitment and retention was one of the most significant challenges faced in these fairly traditional and conservative provinces. But fewer deaths of women and children, less measles, and no polio were convincing even most conservative traditionalists.

In provinces like Zabul and Uruzgan it is quite a decision for persons to engage in the work of CHW, as they may be seen as controversial by certain parts of the community. There is the policy in Afghanistan that CHWs should be volunteers and should not receive a reimbursement, and appreciation of such courageous behaviour is often not given. In fragile states and remote areas, where the poorest of the poor tend to live, there is a good chance that CHWs may have trouble ensuring their own survival. Although officially all public health services are free of charge in Afghanistan, it should be considered normal that CHWs can charge something for their work, and accepted that they receive some incentives. Better than anyone else, CHWs can convince people in their community to change health behaviour if they can show an example. Because salary payment was not an option, AHDS and IbnSina provided some items, which improved the living conditions of CHWs and their families, like bicycles, sewing machines, bed nets, or building materials, because it is not ethical to leave communities without key services and leave volunteers without any adequate reimbursement for their efforts.

Strengthening voice and accountability

As levers of good governance, citizen participation, voice and accountability (V&A) are critical to achieving the transformational change needed to ensure delivery of quality, responsive health services. In Nigeria, commitments to strengthening public participation and voice on health issues are now commonly reflected in federal and state health policy documents, but until recently there was limited practical experience of how to move this agenda forward. Under the PATHS programme in 2003-2008, several states were supported to implement a variety of initiatives designed to increase citizen participation and voice and to enhance accountability (Green and Soyoola 2008). This work fell into three main categories:

- *Supply-side V&A initiatives:* these were facility-based initiatives that aimed to introduce a strong client focus in service delivery. Mechanisms supported by PATHS included patient focused quality assurance, PPRHAA, and integrated supportive supervision (components of IMPACT, described in Section 2.4.3 of this report).
- *Government V&A Initiatives:* these were interventions that helped create a climate within which work on V&A could flourish (e.g. service standards, patient charters, mechanisms for public consultation on health policy and planning).
- *Joint government-civil society V&A initiatives:* these were government-sponsored mechanisms that involved a high level of community participation. Mechanisms supported by PATHS include facility health committees, and provider-community committees overseeing sustainable drug supply systems or health safety nets.

A review of these initiatives carried out in late 2007/early 2008 found that involving clients and community representatives in the assessment and monitoring of service delivery not only helped to open up space for citizen voices to be heard in the health sector, but also strengthened provider responsiveness to client needs. Across the PATHS states, there were many examples of how changes had been made in provider behaviour, or in the way health services were delivered, in response to expressed client and community concerns about poor quality services. The review also found that involving members of the community in the governance of health facilities through Facility Health Committees led to communities challenging a variety of accountability failures, either at the health facility or 'higher up the system'. However, in a context where many Facility Health Committees have been inactive for many years, considerable capacity building and on-going mentoring support are required if these Committees are to function effectively.

Although in the PATHS states implementation of systems strengthening and service delivery improvement initiatives resulted in improved accountability of health providers to local communities, for various reasons the efforts to strengthen accountability between policy-makers and communities proved more challenging. Initiatives that provided a formal mechanism through which citizen voices could reach policy makers seemed to offer the most potential from a voice and accountability perspective. These initiatives not only placed an obligation on different parts of government to listen to the voice of the people, but also introduced incentives to respond. In contrast, where citizens tried to influence policy-makers through informal routes, there was no guarantee that they would get an audience with, or a response from, a policy-maker. These attempts to strengthen voice and accountability were prone to failure in the absence of parallel efforts to strengthen public accountability at local government level. Additional lessons from the work on health systems V&A supported by PATHS include:

- Supply-side V&A initiatives, which allow clients and communities to input to facility and local government performance assessment, translated into greater provider responsiveness to clients and communities and showed much promise as a means of re-building community trust of providers and support for health facilities
- Facility Health Committees provided an opening for increased public participation in health governance. These committees provided communities an opportunity to act as an effective check and balance against provider under-performance or malpractice. However, on-going capacity building and mentoring support was needed to ensure that health committees function effectively. Where this was not provided, performance was weak
- There is potential for evaporation of client and community views in supply-side V&A initiatives, as performance appraisal findings get translated into action plans. This is partly due to the lack of social development skills among providers and managers within the health sector, something that can be addressed through capacity building

- At all levels, there exists only a weak government capacity to manage the multiple demands channelled through public consultation processes, translate these into actionable activities, and to feedback to the public
- Patients' 'bill of rights' or charters can help reinforce the shift in emphasis towards a 'service culture' in the public sector if introduced alongside other performance improvement and accountability mechanisms

2.4 Investing in Human Resources

In health facilities across fragile states, workers struggle to do their jobs in less-than-ideal conditions. The focus of many health services delivery improvements lie in the rehabilitation of facilities and the supply of goods, and oftentimes the wellbeing of the health workers is overlooked. Work climate issues such as poor working environments, unfriendly colleagues, disorganized facility functions and ineffective supervision have been hindering workers' performance and productivity, and contributing to low retention across the world. A recent study on retention of health workers in Kenya identified workplace climate among the non-financial factors affecting morale and motivation (IntraHealth International 2009). Other studies also show that where motivation is low, the resulting poor practices may contribute to low service use. Investment in human resources is crucial to the success of health services delivery. But how can capacity and motivation be rebuilt or created in a manner that avoids dependency, and is sustainable?

2.4.1 Capacity-building

An appropriately trained, well performing health workforce is essential to achieving the best health outcomes possible given the available resources and circumstances. An ideal workforce has sufficient staff, and these are competent, fairly distributed, responsive and productive. Limited health budgets and human resources in fragile states restrict governments' ability to achieve these targets. Where staff is available, their training has often been outdated or of poor quality, and train and hiring health workers and managers at all levels is a considerable challenge. At times, however, there may be local resources available that are easily overlooked because they are not part of the "system", such as refugees or IDPs with adequate training, or national and international NGO staff, which can both contribute to capacity building of the staff of government health facilities without adding a significant financial or training burden to the existing health system.

Building on the momentum of local initiatives

From 1989 to 2004, conflicts in Liberia and Sierra Leone displaced over 500,000 people into the Forest Region of neighbouring Guinea. In 1995, a group of refugee midwives and interested women organised the Reproductive Health Group (RHG) to improve the local services available to their fellow refugees in Guéckédou and Kissidougou prefectures. RHG was supported by GTZ (German Technical Cooperation) with core funding and technical assistance, enabling it to expand its programme. Over three years, RHG mobilised refugee expertise by recruiting and seconding refugee nurses and midwives to local Guinean health facilities. They also trained refugee lay-women to provide RH education, referrals, and contraceptives for the refugee community and used drama groups to reach those less likely to access facilities, particularly young people and men.

RHG achieved good coverage in Guéckédou and Kissidougou camps (e.g. antenatal services covered 56% of reproductive-age women). They also contributed to improving RH service provision in the Forest Region, and increased contraceptive usage and STI prevention and

treatment. Contraceptive usage in these prefectures, at 17%, was much higher than typical for West Africa (UN estimated use of current modern contraceptives for 16 West African countries was 7.9%, with Sierra Leone and Guinea at 3.9% and 4.1% respectively). Additionally, the activities provided income and increased professionalization and self-worth for refugee women, and RHG became an important actor in the health sector.

Although this example comes from a chronic emergency refugee setting, there are lessons to learn for the rebuilding of health systems in fragile states. This is perhaps particularly relevant in the early phases, when people must rely heavily on personal and community-level initiatives. Many examples in this report describe large-scale projects requiring large budgets, but the potential impact of supporting local community-based initiatives with small grants and technical support should not be overlooked. Other submissions in this report describe how international agencies can play a role in the capacity building of local NGOs (Section 2.3.2) and illustrate the impact of small seed grants being made available to jump-start local initiatives (Section 2.7.1). The example of RHG in Guinea reinforces the idea that smaller community-led 'empowerment' programmes, if supported effectively, could have significant impact on public health in fragile states.

NGOs providing supportive supervision in government facilities

Limited health budgets often restrict a government's ability to train and hire health workers and managers at all levels. If it fits within their mandate, NGOs can fill some of these gaps, and HAI programs in fragile states often include training, on-site coaching, and mentoring activities of MoH staff to increase technical skills and improve the quality of managers' supervision. For example, in Timor-Leste, agency staff supports the MoH in six districts in supervising midwives. Survey results in 2008 showed impressive health gains in the districts where supportive supervision visits took place; a national survey planned for 2009 will allow comparisons between HAI-supported districts and the rest of the country. Changes reported in the six programme districts were:

- Antenatal care coverage rose from 50% to 84%
- Skilled birth attendance doubled, from 16% to 32%
- Exclusive breast feeding for children 0-5 months of age more than doubled, from 29% to 67%
- Modern contraceptive use more than tripled, from 7% to 26%

In Côte d'Ivoire, HAI supports government health facilities in the district of Bouaké to expand services related to the prevention of mother-to-child transmission of HIV (PMTCT). A key component of the project's first full year (2008) focused on integrating PMTCT activities (i.e. counselling and testing for HIV) into routine prenatal care in order to reduce loss to follow up of HIV positive mothers, and to increase paediatric care and treatment services. A key component of this effort was coordination with the MoH to conduct recurring on-site coaching sessions for midwives and physicians. This approach minimized disruption for staff and allowed trainings to be adapted to the context of each health facility. While qualitative data is not yet available on how this coaching was perceived by participants, a similar model of "supportive supervision" in the Timor-Leste programme was well received, with participants appreciating the ongoing support and "gentle correction". Due in part to the increased skill of health workers, as well as an improved testing and referral system developed by the MoH with the assistance of HAI, more than 13,000 women attending 17 health facilities were tested for HIV in 2008. Over 96% of patients received their test results, and 77% received antiretroviral prophylaxis treatment. HAI is now working with the Ministry of Health to replicate this successful model in other regions in northern Côte d'Ivoire.

2.4.2 Meeting staffing requirements for optimal services provision

In many fragile states, a large proportion of the health workforce has left the country or migrated to the cities due to the limited number of professional opportunities open to them. This results in overall shortages and imbalances in the distribution of workers that do remain in the country. In addition, the deteriorating skills and capacity of accredited training institutions has often led to the development of different cadres of staff whose competence for safe practice is not easily demonstrable. In the rush to scale up health services delivery during the reconstruction phase, the limitations in the health workforce are often overlooked. There is a tendency to treat the training of a new workforce as an emergency in order to address the urgent short-term needs, while structural support towards the development and implementation of national workforce policies and investment plans are often not prioritised by governments or donors alike.

Private-private partnerships

International Assistance Mission (IAM) operates Noor, an institution which provides a good deal of the eye care in Afghanistan. NOOR has had to face a situation similar to many other medical institutions in Afghanistan and other fragile states: public and not-for-profit facilities operate in the morning, and in the afternoon they are empty while the doctors attend their private clinics. The MoPH has tried to force doctors to work the prescribed hours, but this only works for a limited time. Eventually everything drifts back to the standard routine.

This situation has an important bearing on financial sustainability, which led the project managers of the Mazar Ophthalmic Center (MOC) to institute a number of innovations. The doctors employed by the centre were either given the opportunity to join as full-time staff (i.e. leaving their private clinics) in return for an incentive per surgery, or work as partners (i.e. keep their private clinics), which meant working once a week at MOC in return for a small fee and using MOC facilities in the mornings in return for 50% of the normal fee. Four out of 7 doctors joined the facility full-time, which allowed the facility to open 6 days per week, increase working hours to 4pm during the winter and 6pm in the summer. Same-day surgeries also became a possibility as patients could be operated on in the afternoons. Additional ophthalmic services were also added, and the salaries of doctors were changed by adding the incentives from the surgeries they performed to their set monthly salaries. Fees were increased to reach financial sustainability, but the extra income was also used to increase the poor-fund. A weekly leadership meeting that included representatives from all staff cadres was the forum for all decision-making.

The results so far indicate a good deal of satisfaction from the doctors and staff. It was noted that, unlike previously, doctors now had the incentive to keep the facility running well. In some ways the doctors started leading the way and the staff followed. The staff has taken more ownership, represented by the leadership team. Patients can be operated on in one day, cutting back on their travel time and expenses, while accessibility of services has increased due to the longer working hours. The number of surgeries has increased, as partner doctor bring in cases from their private clinics. Finally, the monthly income increased due to increased activity, which is a step towards financial sustainability.

Creating a new cadre of health professionals

When BPHS was introduced in Afghanistan in 2003, less than 10% of births were attended by skilled providers and its Maternal Mortality Ratio (MMR) was one of the highest in the world. Midwives were few and based mainly in the urban areas, and given that more than three quarter of maternal deaths are avoidable and there is a strong cultural preference for women to use female providers, especially during childbirth, a rapidly mobilisation of female health care providers was essential, particularly in the rural areas where majority of the population lives. The

MoPH accorded high priority to this issue and, in consultation with international partners, took a strategic decision to develop and strengthen a new cadre of health workers called Community Midwives (CMWs), as a key to reducing maternal and neonatal mortality.

CMWs are recognized as key health care providers in the BPHS, not only for the care during pregnancy and childbirth, including Basic EmOC, but also family planning and some elements of baby care. They act as a link to formalized health care, encouraging women to deliver at facilities rather than at home. Guidelines for recruitment and deployment of midwifery students have been standardised to ensure that students are recruited from areas where they can be deployed, effectively supported and supervised after successful completion of training. CMWs are chosen by the key members of their community, with the understanding that they will return to serve that community upon graduation. Training is done through one of the recognized CMW programmes, which follows an 18-month standardised pre-service training curriculum and incorporates the latest scientific and competency-based learning approaches. Upon graduation, CMWs follow a competency based job description which was developed in 2002 and finalised and approved in 2004. Although facility based, CMWs also do community outreach and are accessible at all times. The National Midwifery Education and Accreditation Board (NMEAB), established in 2005, serves as the national technical and regulatory authority for establishment and maintenance of high quality midwifery education in the country. The MoPH Department of Nursing and Midwifery, established in 2005, plays a critical role in overseeing the implementation of the strategies to scale up community midwifery.

Currently 21 community midwifery training programmes are being implemented by various NGOs in collaboration with MoPH. After an initial pilot was completed in 2004, the first official training round was completed in 2006, tripling the number of midwives to 1500. By 2009 Afghanistan had 2,300 CMWs, a great increase but still far short of the 5000 midwives required. CMWs play a pivotal role in the provision of essential obstetric and newborn care and thereby reducing maternal and neonatal mortality. According to the 2006 Household Survey, antenatal care increased from 4.6% in 2003 to 30.3%, skilled birth attendance increased from 6% in 2003 to 18.9 % and the contraceptive prevalence rate from 5.1% in 2003 to 15.4%. CMWs are also making significant contribution, through educating women about health related issues, towards improvement of overall health and nutritional status of the women, their children and families, and thereby the social well-being of the communities they serve. CMWs not only impact on the economic and social toll that losing a wife and mother takes from a family, but they also contribute towards strengthening the overall health system, as they are and will remain for some time to come, the key health care providers to women for priority interventions, especially women in rural areas.

2.4.3 Improving performance

Improving performance of health services often involves linking monitoring of the quantity and quality of services to a reward system for either the implementing party (i.e. an NGO) or the staff of a health facility. A number of examples of how research and monitoring were linked to reward systems can be found in Section 2.7.1 of this report.

Improving service delivery through supervision, appraisal, planning and community participation

In the context of an existing and functional government system, the Nigerian Improved Management through Participatory Appraisal and Continuous Transformation (IMPACT) model led to an improved and sustained level of health service delivery (Anyebe 2008). This PATHS project consists of a combination of four iterative components that work in synergy to systematically appraised health facilities, support improved service delivery, encourage community participation and promote service quality. The four key programme components include:

1. Peer and Participatory Rapid Health Appraisal for Action (PPRHAA). This is a simple but comprehensive process for appraising and collecting information on all the major aspects of a health facility with a focus on service delivery and facility management, as well as the views of clients and other members of a health facility's catchment population. Following the appraisal facility teams plan for improved service delivery.
2. Strengthening Systems and Capacity Building. This involves developing and implementing models for key systems (e.g. Financial Management and Health Management Information systems) and strengthening management capacity.
3. Integrated Supportive Supervision (ISS). This is a unitary supervisory system which uses a common checklist and reporting format based on harmonised indicators from as many initiatives/programmes as possible. It is driven by a common supervisory team.
4. Quality Assessment and Recognition (QAR). This is an approach to assess, recognise and promote quality improvements within health facilities. It involves benchmarking facilities against agreed standards and publicly recognising and promoting the outstanding facilities.

IMPACT is based on a pro-active but firmly non-prescriptive step-by-step methodology that responds to the level partners have attained and moves at a pace that keeps them involved. It increasingly empowers partners to take leadership and assume ownership of reform activities. It requires a deep level of participation, shared vision, joint development of strategies and local determination of priorities from all participants. Some states developed the components further than others and structures also varied from state to state, so flexibility was important as the IMPACT processes needed to be embedded within the systems of each state.

IMPACT was used as the leading systems strengthening and capacity building initiative for six years (2002 to 2008). It provided a framework and a platform on which significant other work was built and resulted in many deliverables that were both locally appropriate and globally relevant, such as the regular creation and updating of action plans that were implemented at an increased rate, a reported increase in utilisation for most health facilities, improved management performance scores over the years, and the institutionalisation of feedback. The process was a key catalyst for reforms at all levels of the health sector, including the community, facility, State Ministry of Health (SMOH) and Local Government Area (LGA) levels, supported by the development of leadership skills to drive reform. In addition to booking successes, a number of key lessons were learned:

- There was a need for a strong in-state team that could gradually take over from the programme's consultants
- Teams needed to be independent and objective for the implementation of ISS & QAR
- Each component of IMPACT functioned independently but was also highly inter-related with the other components
- There needed to be a gradual simplification of the process and progressive funding by local government bodies such as the SMOH and LGAs to achieve success

Another indicator of success has been that apart from PATHS, other Nigerian national bodies and programmes have increasingly bought into the IMPACT methodology, including the National Primary Health Care Development Agency, tertiary health facilities, Christian Health Association of Nigeria, Evangelical Churches of West Africa, the Partnership for Reviving Routine Immunisation in Northern Nigeria, and Save the Children UK (Nigeria). All these organisations were utilising one or more components of IMPACT by early 2008.

2.5 Managing Financial Resources

Developing countries will need between US$ 25 - US$ 70 billion in additional aid per year to remove the financing constraint to scaling up to meet the Millennium Development Goals (MDGs) (Dodd, Schieber et al. 2007). It is often politically advantageous for donors to raise and spend aid "vertically", in order to show a direct link between their tax monies, and results. While this is an issue in all sectors, the consequences are particularly acute in health as the sector requires flexible resources that can be used to support recurrent costs and health systems. While many donors recognize the need to provide flexible funding to support country-owned health reform plans, concerns about public sector management and governance, particularly in fragile states, may make them reluctant to do so (Cassels, Dodd et al. 2008). Stronger financing mechanisms for health service delivery are therefore required. There is a need for more innovative financing models, and better ways of planning and budgeting for health service delivery.

2.5.1 Managing multiple financing streams

Performance-based financing (PBF) is currently seen as a powerful means of increasing the quantity and quality of health services by providing incentives to suppliers to improve performance. A PBF program typically includes performance-based grants or contracts, with indicators selected to encourage the increase in use and quality of health care services, stabilize or decrease costs of these services, help use limited resources effectively, and improve staff motivation and morale. The example below describes how the effects of vertical funding streams, which were negatively affecting performance in other sectors, were counterbalanced by the use of PBF. Sections 2.2.1 and 2.7.1 of this report give examples of PBF from Afghanistan, where it was used to improve staff morale and performance at health facility level. Additionally, this section also describes an example of how basket funding was used at a decentralised level to synergise horizontal and vertical funding streams.

Using Performance-Based Financing to correct service imbalances

In the DRC, over 50 vertical disease-specific programmes exist. A significant increase in funding for disease-specific programmes during recent years has been contributing to further destabilisation of an already weak heath system. As both a sub recipient of UNDP/GFATM funds for a network of 18 partners, and a direct partner of most of these organisations, Cordaid attempted to maximise synergies between the different horizontal and vertical funding streams. However, the evaluation of the DRC HIV/AIDS programme in February 2008 revealed that although important 'vertical' results were achieved, the programme had had negative effects on other health activities, as both human and financial resources had been primarily focused on the vertical activities.

In an effort to strengthen overall health services provision, CordAid therefore introduced the concept of PBF in its programmes in the DRC. Based on a predetermined set of qualitative and quantitative output indicators, each health facility is rewarded according to its performance, providing the health facility management an income to finance its business plan. The subsidies linked to each indicator are normative (based on desired outcome) and are determined by a provincial health forum that ideally consists of representatives of *providers* (MoH, NGO's, and the private sector), *purchasers* (insurers, local administration or NGO's), *regulators* (MoH), *fund holders* (MoF, international donors) and *consumers* (patient groups).

Cordaid evaluated its PBF programmes in DRC in 2008. PBF health facilities had comparable or better results in terms of output, quality and equity despite the fact that financial investments in non-PBF health facilities were overall larger. Autonomously managed PBF health facilities had

better access to essential drugs from competitive distributors than non PBF facilities supported by NGOs applying a central distribution approach. For 13 out of 20 indicators the PBF districts had significantly better results, while the non-PBF districts scored better for two indicators.

Most PBF schemes in place are recent initiatives and can only report short-term impact. Careful monitoring needs to take place over the coming years to demonstrate their longer-term impacts. It is felt that PBF can make a significant contribution in fragile states due to the introduction of autonomous fund holders that can counterbalance a power vacuum in the short term. It can also have long-term reform potential by promoting good governance.

Creating synergies in horizontal and vertical funding streams

Despite international agreements on harmonisation and alignment like the Paris declaration in 2005 (High Level Forum on the Health MDGs 2005), Cordaid faces an enormous challenge to finance a single programme of health activities funded by different donors. Donor requirements such as reporting guidelines, indicators used, audit requirements, and proposal guidelines often don't match. For example, GFATM and the European Union (EU) use different sets of indicators to measure results of identical activities. This creates a need for parallel monitoring and reporting for the different contract modalities, subsequently leading to extra administrative burdens. In the DRC, where PBF has led to health systems having an independent budget, the complete system of demand (patients), supply (hospitals and other institutions), financing (own contributions, government and insurance), and regulations in the field of health care in a specific region is closely examined and organised on the basis of PBF. To this end, separate offices have been created (*agence d'achat*, AC) that are responsible for 'purchasing' health care services. ACs sign contracts with care institutions and pay them on the basis of indicators (services provided).

In the DRC, Cordaid acts as a sub-recipient for Global Fund/UNDP (Round 8) and is also contracted by EU (9 EDF) for PBF programmes. In order to meet donor requirements, Cordaid has had to 'force' partner organisations to develop parallel reporting and accounting systems for each of the vertical funds supporting the services being provided. This led to complicated record keeping and accounting systems, and an increased burden for an already fragile health system. It was thought that ACs could play an important role in the harmonisation of administrative tasks as this can take place when they 'purchase' results from individual service providers using different financial resources. Therefore, in two regions of DRC, Kasai and South Kivu, Cordaid now works with the ACs and their stakeholders to bring together the different donor reporting requirements (i.e. Global Fund and EU). The AC is used as the central 'basket' for depositing both horizontal and vertical funding streams. This allows for negotiating harmonised service delivery contracts with the individual service providers.

Although the idea does have its successes, in practice the ACs only succeed to negotiate aligned contracts covering 60% of the indicators. For the remainder of activities, parallel contracts still need to be issued. However, negotiations are being conducted on a permanent basis, and the aim is to be able to succeed in negotiating adaptation of indicators and modalities to enable the ACs to contract service providers for the entire package through a single contract funded by different horizontal and vertical donors.

2.5.2 Planning and budgeting

A good health financing system raises adequate funds for health in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It promotes treatment according to need, and encourages providers

to offer an effective mix of curative and preventive services. Achieving this involves three interrelated functions: the collection of revenues (from households, companies or external agencies); the pooling of pre-paid revenues in ways that allow risks to be shared; and the purchasing of interventions or services. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Most systems involve a mix of public and private financing and public and private provision. Prepayment mechanisms such as taxation and health insurance are generally non-existent in fragile states, resulting in limited public health services provision. Populations with high levels of poverty and a high burden of disease are therefore highly reliant on the private sector for health services, where out-of-pocket payments contribute to a risk of financial catastrophe (Poletti 2003). Proper planning and budgeting can assist a government in providing an optimal package of cost-effective services that optimises access by the poorest of the poor.

Developing Planning and Budgeting Systems

In Nigeria, planning and budgeting were not seen or deployed as core or integral parts of programme implementation and performance management. To address the absence of systematic links between policies, plans and budgets, the PATHS project adopted a number of strategies to address poor planning and budgeting (Allison 2008). These strategies primarily centred on (1) agreeing with the SMoH and other stakeholders on what might be achieved in the annual (operational or business) planning and budgeting cycle and (2) supporting strategic planning. For annual operational planning and budgeting, specific strategies focused on:

- Alignment with State Annual Planning and Budgeting Cycle
- Establishing state planning and budgeting teams to drive the process
- Implementing new Budget Codes (developed by the Federal Ministry of Finance - FMOF) and a modified Chart of Accounts
- Developing and applying new planning and budgeting formats
- Preparation of facility and departmental plans and budgets (aligning them with SMOH & LGA plans)
- Strengthening budget processes: preparation, review, presentation and defence
- Building planning and budgeting capacities and systems
- Linking revenue planning and budgeting with expenditure

Significant steps were taken in all these areas to strengthen annual planning and budgeting, and by early 2008 Strategic or Medium Term Plans were completed, or were nearing completion, in all states where PATHS was operating. Key features of these efforts included:

- Using the opportunity of the State Economic Empowerment and Development Strategies (SEEDS) to ensure health sector strategies are rooted in wider state strategic planning processes
- Equally using the (strategic planning) opportunities presented by the introduction of key political health initiatives and imperatives; this included in particular the launch of State “Free MCH policies”
- Consolidating multi-year national vertical programme plans – to minimise the problem of multiple ‘free-floating’ plans.
- Using the strategic planning processes to lay the groundwork for wider structural, institutional and organisational reform in the State health sector (this includes the District/Gunduma health systems reforms in Enugu and Jigawa, and the Organisational development reforms in Kaduna described in Section 2.2.3 of this report)

These strategic plans were in some cases still only “state health plans”. By early 2008, efforts were underway to prepare “health sector” plans that fully encompassed PHC and Local Government responsibilities for this part of the national health system. In states where a Demographic and Health Survey (DHS) approach was operating, the plans were already broader based – down to PHC level. Further efforts will be required to consolidate this process as many of the health programmes, including national programmes, were used to planning on their own, without reference to a wider state strategic plan. Key lessons to remember were found to be that strengthening state planning and budgeting is an ongoing process, with inputs throughout the years and over a number of years required to bring systems to a minimum level of effectiveness. In the process, alignment with the planning and budget cycle is crucial, and all too often forgotten (i.e. by development partners). The nature of the alignment can be shaped by stakeholder dialogue, and may vary according to needs and circumstances. Key to the success of budget processes are an adequate Budget Classification and Chart of Accounts, which can be linked to the introduction of state public sector Integrated Financial Management Systems (IFMIS) capacity building. The process of engagement and involvement re-created the culture of planning at all levels, leading to a wider acceptance and recognition of the need and value of the plans and associated budgets.

2.6 Supply Chain Management

Indicator 5 of the Paris Declaration (HLFHealthMDGs 2005) is concerned with the use of country procurement systems. Beyond the broader issues of transparency and lack of corruption, using developing country systems to procure medicines and health equipment may raise issues unique to the health sector. First, quality is more important than it is for other kinds of products, which adds extra risk with local suppliers and systems. Counterfeit drugs are a serious global problem carrying both large financial and individual health risks. Second, international trade rules around intellectual property rights of pharmaceutical patents can pose challenges for procurement efforts. Finally, as access to medicines is an inherently political issue, governments are often under pressure from donors and activist groups to invest in particular treatment regimens or drugs which may not be available locally (Dodd, Schieber et al. 2007).

2.6.1 Developing Sustainable Drug Supply Systems

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. To achieve these objectives, WHO suggests that the following are needed: national policies and regulations; information on prices, international trade agreements and capacity to set and negotiate prices; reliable manufacturing practices and quality assessment of priority products; procurement, supply, storage and distribution systems that minimize leakage and other waste; and support for rational use of essential medicines, commodities and equipment.

A centralized procurement, supply, storage and distribution system seldom exists in these contexts, and where it does, it often lacks proper resources and is very vulnerable to leakage and corruption. With the high reliance on UN agencies and NGOs for health services provision, supply systems in fragile states also tend to be fragmented, with each agency responsible for its own logistics supply cycles, training and guidelines. One common way to address some of these problems is to set up revolving drug funds, as outlined below.

Drug revolving fund

Acute shortages of drugs and medical supplies in public health facilities are endemic in most fragile states, as they were in most states in Nigeria. These shortages significantly undermined efforts to improve health care delivery under the PATHS programme, which is why, early on in the programme, participating states established Drug Revolving Funds (DRF) for secondary and primary health care levels (Egume and Vreeke 2008). In order for these funds to be robust, the drug supply systems required an underpinning financial management system and an assured source of drug supply. It was also necessary to introduce a 'safety net' to ensure that the very poor and vulnerable could access quality drugs through the system. In some states, free MCH services were developed and provision of drugs for these groups needed to be included.

The DRF system was not a new concept in Nigeria. Nigerian states had tried different DRF approaches including centralised state controlled schemes, the Petroleum Trust Fund and 50% Cost Recovery DRF systems. None of these was particularly successful for a variety of reasons, and at the start of the PATHS DRF project, there existed not only to a backdrop of acute shortages of drugs/consumables and a poor culture of financial transparency and accountability, but also many variants of unofficial (parallel) DRFs and the entrenchment of bad practices across facilities. In 2003, as a matter of strategy, the DRF models developed earlier in Nigeria were reviewed and a new model was designed capturing the best elements of previous models, taking into account lessons learned from previous implementation experiences. The review indicated that four interventions were required for a successful and sustainable DRF scheme:

1. Establishment of facility-based DRF systems
2. Strengthening financial management systems
3. Creation of a safety net for the very poor
4. Establishment of an assured source of drugs

Initially, the focus of the programme was on establishing the DRF and financial management systems. Then, in some states, safety nets for the very poor were introduced. Finally, establishing or strengthening existing state Medical Stores was addressed in order to provide an assured source of drugs and medical supplies for health facilities. All stakeholders recognised that involving a critical mass of health facilities in the sustainable drug supply initiative was needed in order to have a measurable impact, therefore state-wide roll-out took place once the DRF model was tried and tested in a few facilities.

All PATHS supported states rolled out a sustainable drug supply system across the state. A key strategy was the development of in-state teams of facilitators thus ensuring sustainability and local ownership. Strong community representation on DRF and facility health committees improved relationships between facilities and their communities. Drug availability increased community confidence in their facilities and, in turn, made communities stronger advocates for their local health facilities. With evidence of increased patronage of facilities, government support for the DRF and for strengthening of financial management systems increased over time, albeit in varying degrees.

Key lessons learned from the exercise in Nigeria include (1) the need to implement DRF in a holistic manner (i.e. addressing the total environment within which it will operate); (2) the importance of strong and continuing advocacy in support of the scheme at all levels; (3) identifying and applying an appropriate personnel mix; (4) the importance of state-wide rollout resulting in 100 percent population coverage; and (5) the fact that sustainability is dependent on the presence of a robust monitoring and evaluation system, strong community participation, and the introduction of performance based incentives to operators.

Lessons learned: factors for scale up and sustainability of a Revolving Drug Fund

In the mid 1980's in partnership with the Khartoum State Ministry of Health (KSMOH), Save the Children UK developed the Khartoum State Comprehensive Child Care Programme (KCCCP) which ran from 1989-96. The broad aims of the KCCCP were to improve the capacity of the KSMOH structures, particularly at provincial level, to effectively manage and target operational support to primary health care facilities; to produce results which produce direct benefits to children by improving, and maintaining, the quality of services; and to support activities at community level which increase availability and utilisation of services. In addition, the Khartoum State Revolving Drug Fund (RDF), was established to (1) ensure access to an adequate supply of affordable, quality essential drugs and medical supplies at below prevailing market prices and (2) to encourage the rational use of drugs. This was to be achieved through establishing an effective and efficient drug supply to KSMOH health facilities using robust management, financial, human resource and pharmaceutical systems, in addition to ensuring that revenues collected from drug sales were used to replenish drug stocks, and encouraging more effective use of health services and rational drug use.

The RDF imported drugs from non-profit suppliers abroad, or from local sources, where these were available. A committee made up of RDF management and PHC representatives selected the drugs from the Sudan Essential Drugs List. These were then sold on at cost, plus a mark-up to cover overall running costs (including reserves against devaluation etc.). A system of internal cross-subsidies was developed, that involved subsidising supplies to public health centres through the high-volume sales through the People's Pharmacies, complementing common cheaper drugs with more expensive ones, and using revenues from central facilities to support more distant rural ones. Drugs were delivered to RDF-supported pharmacies in the health facilities based on previous consumption patterns. Funds were collected monthly, against sales records.

Starting with 13 health centres in 1989, the RDF expanded to 77 outlets (65 health centres and 12 rural hospitals) by 1996. $1.8 million was invested in capitalising these outlets. In 1996 the RDF became an independent project within the Khartoum MoH and in 2002, a constitutional decree established the RDF as an independent foundation, responsible for the medical supply in Khartoum State. At the same time, 7 RDFs were set up in other states by Central Medical Supplies. Since the handover of full management of the RDF to KSMOH, growth has continued. In 2005, the RDF supplied 113 health centres, 20 hospitals, and 22 community pharmacies. To run these it had a staff of 495. It has been operating successfully for 20 years and in 2004 had an annual turnover of around £2 million. In 2003, it dispensed drugs to 1.2 million patients.

The question as to whether the RDF, and the broader KCCC programme, has had sustained impact was a subject of a series of evaluations culminating in a final evaluation in 2005. The evaluation found that the RDF was clearly viable, nearly a decade after hand-over. It has taken over full costs since being handed over, it has expanded both its network and its coverage, and it has maintained its cost advantage over rivals. The RDF is continuing to fulfill its original mandate and is providing high quality, appropriate essential drugs at lower cost than the market alternatives, as well as a range of other public services. The RDF still operates an equal price list across the state, which benefits more outlying and rural areas, and passes on transfers worth 210 million SDD each year to the KSMoH. These transfers alone are larger than the value of the tax exemption which is granted on its imports.

Overall access to health facilities and the RDF services was good. A household survey also suggested that public facilities – health centres and hospitals – are widely used. The health facility results suggested a reasonable degree of geographical equity in terms of the facilities and their

quality. Quality standards, including rational drug use, were overall good and had been maintained over time. But there were considerable discrepancies by income group which suggested that pro-poor measures were necessary. Such measures could operate through the RDF or through wider mechanisms and could include extending health insurance coverage to disadvantaged groups, increasing the overall health budget, providing health care free at the point of access for vulnerable groups and improving administration of the Zakat system.

The key elements to the success of both the programme, and ones that can be translated to other programmes are:

- The substantial and phased investments, not just in drugs and capital investments such as infrastructure and vehicles but also in training and systems development
- Its long period of development and support: for example it was ten years before the RDF was expected to be autonomous
- The early emphasis on efficient systems and capacity building – of both KSMOH staff and RDF staff (e.g. defined roles and responsibilities for staff and robust financial and logistics management, and a continuing education programme)
- Sustained political support, at the highest levels in Khartoum State, which have enabled the RDF to manage external threats (e.g. to its financial independence)
- Supportive policy environment (e.g. the tax exemption from customs duties, which enabled it to undercut competitors' prices, at least for imported drugs)
- A focus on operational research to improve the impact and efficiency of the programmes- both before and after the programme was handed-over.

2.6.2 Innovative cost-reduction schemes

The challenge faced by any government and agency in the provision of health services is to achieve the balance between price, and quality or impact in the strategies it pursues. Many commonly used strategies such as vaccination have already proven to be cost-effective and are widely implemented. At the same time, complex donor policies and the need to import and transport large quantities of supplies that can be bulky can actually lead to increased costs and burdens to a system which, in fragile states, faces considerable budgetary and infrastructural challenges. This section briefly describes one approach that could contribute to a savings, and therefore improved cost-effectiveness of a health system. An approach to pooling funds, which could also contribute to increased cost-effectiveness, is described in Section 2.5.1.

Public-private partnerships for the local production of essential drugs and supplies

In the 1990s, during the Balkan war, one of the MSF sections converted a disused factory into an active one, starting the local production of intravenous fluids, which were heavy, bulky and therefore costly to transport. This not only created work for the local populace, but with regular sniper attacks on convoys, the reduced requirement for transport of bulky materials also translated into an added security bonus.

This concept of locally manufacturing bulky materials that do not require highly complicated or advanced production mechanisms can also be adopted by the private sector. Nutriset, a privately owned French company involved in the production of nutritional products, is probably most well known for its production of Plumpy'nut, a ready-to-use therapeutic food (RUTF) used in home-based treatment of severe acute malnutrition using the Community-based Management of Acute Malnutrition (CMAM) model. Due to the success of RUTF for home-based management of severe malnutrition, Nutriset works in close coordination with UNICEF and national Ministries of Health to

ensure the sustainable availability of a range of products in countries where under-nutrition remains a chronic issue. The company has developed a network of local franchise partners in the food industry called “PlumpyField,” the core of which is based on the transfer of technology and know-how from Nutriset to a local food producer in user countries. To date, 6 local producers comprise the PlumpyField network: Malawi, Niger, Ethiopia, the Democratic Republic of the Congo, Mozambique and the Dominican Republic. The network is expanding progressively and will soon include Ghana, Tanzania and Madagascar. Plans are also in place to assess the feasibility of expanding the network into more fragile states and studies will be carried out in the Sudan, Yemen, India, Cambodia and Pakistan in 2009 / 2010.

In addition to the transfer of technology to local food producers, Nutriset works to establish links with relevant stakeholders at the local level. A specific example exists in the Sudan, where the School of Food Technology of a local, all women’s university is providing training to producers of raw materials, such as peanuts and oils, to ensure proper methods are used to mitigate aflatoxin and peroxide levels. This initiative is an example of how the establishment of partnerships between the public and private sector can lead to the strengthening of human resource capacity by providing technical and managerial experience, and ultimately benefiting the local economy as well as ensuring a reliable supply of life-saving goods.

2.7 Health information systems

The generation and strategic use of information on health and health systems is an integral part of the leadership and governance function of a health system, and requires a well-functioning health information system (HIS) which ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. Monitoring and reporting progress/impact requires facility and population based information and surveillance systems, but these tend to be weak or non-existent in fragile states. Instead, health information in these states relies heavily on local surveys conducted by NGOs, or on national surveys such as Demographic and Health Surveys (DHS) or the Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF. Surveys pose significant methodological and logistical challenges, and results can be contentious. Reliable population figures for the calculation of coverage and morbidity/mortality rates is frequently unreliable in these settings, as census data tends to be incomplete or severely outdated and insecurity can result in significant (cross-border and internal) population movements. Nevertheless, they are often the source of “best data” in fragile states.

There is no blueprint for an ideal monitoring and evaluation (M&E) strategy for any country, and tools for implementation are described, although in a limited way, in the existing literature. This section pulls together examples of how the results of monitoring and/or evaluations have been used for improvement of services in fragile states, and ends with a challenge to agencies to start pulling together common research agendas. Inclusion of governments in such priority-setting exercises is a concept that may lead to mutually beneficial results and agreements.

2.7.1 Translating research and M&E findings to services improvement

The main objective of M&E is to gather evidence as to whether a strategy or programme is having the intended effect. The results of M&E approaches can then be used as a platform for change and improvement, and a new phase of the planning cycle for the particular initiative. M&E is the subject of much thought and debate, and a multitude of approaches exist for its implementation. A popular tool is the use of a Scorecard. In Afghanistan the Balanced Scorecard is used by an independent third party to monitor the performance of the health system (Hansen, Peters et al. 2008). The April 2009 revision of the Somali EPHS package includes a Score Card for health

facilities that is to be used in conjunction with Supervision Checklists designed to enhance staff performance. In both cases the Scores are generally made up of measurable indicators that focus on child and maternal survival and reflect targeted priorities for improving facility performance, such as record keeping and staff performance indicators.

Numerous challenges exist in implementing M&E strategies. Especially during transition periods, where the focus of many projects is on scaling up of services, data collected during national surveys and at local level is often not fed back to the service providers in a systematic way. There is often also little incentive to the service providers to review or use the findings. The examples listed below indicate how linking results of surveys and routine data collection to incentives for improvement can yield positive results. The first example describes the Inter-agency Health and Nutrition Evaluation Initiative, and the second examines the effect of providing seed grants to NGOs to help them take action on reproductive health survey results in Liberia. The third example comes from Afghanistan, and is an early experiment in the implementation of performance-based reward systems in health care.

Inter-agency health and nutrition evaluations as a tool to improve accountability

Every year, hundreds of millions of dollars are spent in support of health and nutrition programmes for refugees, internally displaced persons, and other populations affected by humanitarian crises. The complexity of the health and nutrition sector, and the scarcity of evaluative efforts at the sector level led to the creation of the Inter- agency Health and Nutrition Evaluation (IHE) Initiative. Created in 2003 by a group of UN agencies, NGOs and other institutions involved in humanitarian assistance, it aimed to fill the gap by commissioning inter-agency evaluations focused on the health and nutrition sector. It was guided by a Core Working Group that included various NGO and UN agencies. Six evaluations were commissioned in Nepal (September 2003), Zambia (November 2003), Pakistan (December 2003), Burundi (April 2005), Liberia (September 2005) and Chad (February 2006). The ultimate aim of these evaluations was to improve the performance of the health and nutrition sector, to decrease threats to the lives and health of affected populations, and to enhance the collective accountability of the health and nutrition sector.

These evaluations traversed agency and national boundaries to examine the coverage and impact of health and nutrition interventions on populations affected by a humanitarian crisis. They analysed the overall performance of the health and nutrition sector, and identified gaps and overlaps in programming. In addition, they provided the evidence base for re-orientation and improvement of the health and nutrition response, and became part of the on-going planning process. Based on the experience of the IHE initiative to date, the IHE Core Working Group developed practical guidelines for conducting inter-agency health and nutrition evaluations (IHEs). These described how to do an IHE, outlining a suggested evaluation framework and evaluation methods, as well as describing the process of managing the evaluation.

Experiences over these four years highlighted challenges as well as good practices on how to do these types of evaluations. IHEs should be initiated, managed and funded by field level coordination mechanisms in order to maximise ownership, relevance, and institutionalised responsibility for implementation of recommendations in the field. To achieve this, various mechanisms were devised by the IHE initiative including pre-visits, the creation of local steering committees, and follow-up visits. However, funding remains dependent on external support as long as such evaluations are not routinely included into national humanitarian planning processes. Furthermore, the success of IHEs depends on participatory and inclusive leadership. Inclusion into international planning processes, such as the Inter-agency Standing Committee (IASC) health and

nutrition clusters, would help. Despite these remaining challenges, the IHE resulted in a better understanding on how health sector-wide evaluations could add value, and insights into how to do them. This warrants further implementation and refinement of this tool, as well as possibly inclusion into IASC cluster operations.

Decision Linked Research: Building capacity at the local level to improve RH in Transition

As a result of poor security and accessibility to communities, local NGOs are often the only organizations providing health services in post-conflict states. Given the current trend in contracting out health services delivery to NGOs during the early recovery period, these NGOs will play a vital role in shaping the future health system during the transition period. National surveys are often conducted early on in the reconstruction phase to assist in identifying specific health needs and service gaps.

In Liberia, a promising decision linked research-to-action model demonstrated that involving local health NGOs in the design, implementation, dissemination and funding plans for a population based reproductive health survey enabled NGOs to address critical gaps in reproductive health (RH) services. The initiative was a collaborative effort among the Ministry of Health and Social Welfare (MOHSW) of Liberia, the U.S. CDC, JSI Research and Training Institute, UNFPA and USAID. After completion of the RH survey in 2007, the four local NGOs involved in the programme were given small grants of $10,000 to address the survey recommendations. The four local agencies developed logic models and monitoring and evaluation plans using the data from the survey to address RH gaps during a period when resources and robust data for programming were scarce. Capacity building in RH service delivery and organizational strengthening were provided every two months to improve sustainability of the programmes.

One year after programme commencement, evidence suggests that relatively modest investments, in the form of small grants and capacity building, enhance the effectiveness of local organizations. The seed grants helped the NGOs build an organizational base and track-record, and increased organisational sustainability by creating the opportunity to leverage additional funding from other donors. The project also resulted in the establishment of in-country and external links. The NGOs collaborated with the MOHSW at county level by supporting MOHSW-identified priorities, and linked with each other within and outside Liberia by sharing lessons learned at national workshops and an international conference. At the end of the first year, all four NGOs had expanded the number of areas of RH covered. Programme managers and staff demonstrated increased knowledge and skills in relation to the delivery of quality RH programmes.

Linking incentives to monitoring for the improvement of service provision

Two years after the onset of Swedish Committee for Afghanistan's programme for implementing the BPHS in Wardak province of Afghanistan, the programme evaluation found that scaling up of health services had been tremendously successful. The number of health facilities in Wardak was the highest of any of the provinces in Afghanistan, but there were some shortcomings. These facilities were unequally distributed across the population, and many were not yet functioning properly. The evaluation was the impetus to shift the programme's focus from scaling up to quality improvement, with M&E playing a key role in decision-making.

The first step was to clearly define the boundaries and population of the catchment area of each health facility. A number of indicators and targets were identified to define the standard level of activity of each health facility. These indicators included number of consultations, fully immunised children, antenatal visits, growth monitoring, contraception prevalence rate, and TB case

detection. Data on these indicators not only reflected pre-established programme targets and was collected through the routine monthly Health Management Information System (HMIS) reports, but progress was also monitored by a third-party survey on an annual basis through a national survey. Where normally HMIS data was sent to the central MoPH and no further action was taken or feedback provided to the health facilities, the Wardak BPHS analysed the data on the key indicators, breaking them down into levels of activity per staff member and per 1000 population. Results were presented on graphs, which illustrated the progress each individual health facility was making towards the programme target, and results sent to each health facility on a monthly basis.

Although at programme level results of these analyses guided decisions into staff reallocation, closing of facilities and the opening of new static or mobile facilities, the data was also used as the basis of an incentive system for health facility staff. Bonuses were paid to the staff of health facilities showing the most progress towards achieving their estimated targets. These performance-based incentives were tied to some basic rules:

- The total bonuses paid at one time could not represent more than 5% of the total salaries paid to the staff of the health facility
- If a health facility was selected to receive a bonus, all staff members received the same bonus in terms of relative percentage of their salary
- The bonus paid at one time could not exceed the value of two weeks' salary
- If a health facility was selected to receive a bonus, it was exempt from receiving a bonus during the following three months. Facilities could not receive a bonus more than three times per year.

Three months after onset of this incentive system, it was noted that staff motivation had considerably increased. It also appears that this approach, which was not implemented in other provinces at that time, had some sustained results. Of the 30 provinces surveyed in 2005 and 2006 for the third-party evaluation, Wardak received the second-highest average score on the Balanced Scorecard across 29 indicators, including the highest score on health worker satisfaction for all provinces in 2005. This compared to 2004, before the onset of this project, when Wardak was ranked in the lower 50% of the provinces (Ministry of Public Health of the Islamic Republic of Afghanistan, Johns Hopkins University Bloomberg School of Public Health et al. 2006).

2.7.2 Establishing a common research agenda

Although research is being conducted in fragile states, much of it is haphazard and very much linked to institutional and personal interests of local actors. In addition to the local security constraints that often do not make fragile states attractive research locations, available funding streams tend to, very understandably, primarily target emergency assistance and reconstruction efforts, but do not prioritise research. Nevertheless, with some of the worst health indicators in the world, and a poor understanding of how their health infrastructures function, it is important to do more research to improve the health outcomes of populations of fragile states (Bornemisza, Zwi et al. 2008).

One way to address the research gaps in fragile states is for key stakeholders to establish common research agendas on key subject areas. In this way the resource and research burden can be distributed across stakeholders, resulting in a more efficient and effective use of the limited funds available while still getting key questions answered. Tearfund took the initiative, during the international HIV conference in August 2008, to explore with key stakeholders the research that had already been done on HIV in fragile states, with the aim to identify gaps and challenges. As a

result of this meeting, a number of key areas for further research were identified. These included Gender Based Violence (GBV), RH in emergency settings, ART adherence in emergency settings, adult malnutrition and HIV in emergencies, service delivery models in the different contexts of fragile states, and reasons why IASC guidelines are not used. Tearfund has committed to working together with other stakeholders in addressing some of these key research areas. If such a research agenda were linked to a comprehensive research implementation plan that allocates specific research projects to specific partners, this approach could make a significant step towards getting answers to key questions, ultimately benefiting the health outcomes of some of the poorest and most vulnerable populations in the world.

3. Conclusions

3.1 Key messages

Based on the experiences described in this report, it seems that many health actors in fragile states are taking a HSS approach, despite the considerable challenges in trying to set up and support health systems in fragile states. There is great creativity and diversity in approaches, which address all components of the health system, from drug supply systems to financing. Overall, there are a few common elements in a number of these approaches:

- Community involvement is embraced as a key to ensure sustainability and security of services.
- There is recognition that there is no simple, single approach that will work. Programmes tend to consist of multiple elements, not only focusing on service delivery but also addressing causes of low service utilisation, investing in staff, improving community awareness and participation, and harnessing local capacity to achieve sustainability.
- Many programmes have gone beyond stand-alone, vertical services provision, and seek to achieve integration with existing services and systems.
- Most initiatives do not work on short time-lines. Sustainable successes seem to have been achieved when investments were made over the longer term.
- Most approaches attempt to build a diversity of partnerships, working with everyone from the community to overseas academic institutions.
- The recognition of the importance of financial support: small seed grants to support local initiatives can have significant long-term impacts.

3.2 Challenges

Overall, the submissions included in this report indicate that there is great innovation and diversity of implementation experience by health actors in a variety of fragile settings. This is a strength, as experimentation will lead to the field testing of various models of implementation of HSS initiatives. However, the challenge is to do additional and better evaluation and operational research, as very few of the projects submitted had evaluations to back up the perception of those involved that these projects work. More effort and funding are thus required to measure changes in health planning, management processes and health outcomes. More exploration is also required on how to work within governance constraints, and on the impact of poor governance on health initiatives.

Overall, the submissions indicate that HSS approaches are relevant in all contexts (conflict, transition, post-conflict and weak governance situations), and that while the context drives the details of implementation, good ideas can be adapted to various settings. The major challenge remains how to strengthen health systems in fragile states so that they have good coverage, are responsive and affordable, and improve health outcomes.

4. Contributing Authors and Organisations (sorted by country)

Title *(click on the title for a hyperlink to the relevant section in the document)*	**Country**	**Author names**	**Affiliation**
A Basic Package of Health Services	Afghanistan	-	Afghan Ministry of Public Health
A community-centred approach to improving child health	Afghanistan	Nichola Cadge	Save the Children UK
Addressing disability through Community-Based Rehabilitation	Afghanistan	Anne Herzberg	European Commission
Community Participation	Afghanistan	Jaap Koot	CordAid
Contracting out of services	Afghanistan	Abdul Wali Ahmad Jan Naeem Ashfaq Ahmed	Ministry of Public Health WHO
Creating a new cadre of health professionals	Afghanistan	Najla Ahrari Pashtoon Azfar Abdul Wali	Ministry of Public Health / MSH
Integrating psychosocial counselling services into a national service delivery mechanism	Afghanistan	Inge Missmahl	European Commission
Leadership and the need for developing institutional capacity	Afghanistan	Katja Schemionek Nel Druce Aqila Noori Ahmad Shah Salehi	HLSP Ministry of Public Health
Lessons learned in scaling up reproductive health services	Afghanistan	Louise Lee-Jones	Marie Stopes International
Linking incentives to monitoring for the improvement of service provision	Afghanistan	Philippe Bonhoure	Swedish Committee for Afghanistan
Organising services: An Essential Package of Hospital Services	Afghanistan	Miya Ashraf Aaron Beaston Blaakman	Ministry of Public Health EPOS
Partnerships between national and international NGOs for services provision	Afghanistan	Fiona Campbell Fayaz Ahmad	Merlin
Prioritising Mental Health and Disability services	Afghanistan	Anne Hertzberg Inge Missmahl Peter Ventevogel	Ministry of Public Health HealthNet TPO
Private-private partnerships	Afghanistan	Elliott Larson Bernard Schoeman David Brooks Dirk Frans	International Assistance Mission
Providing basic mental health care through public and community structures	Afghanistan	Peter Ventevogel	HealthNet TPO
Providing incentives for accessing and delivering services in insecure areas	Afghanistan	Emanuele Capobianco Ghulam Dastagir Sayed Benjamin Loevinsohn Kees Kostermans Homira Nassery	Ibn Sina World Bank
Integrating existing mental health services into government structures	Burundi	Peter Ventevogel Herman Ndayisaba	HealthNet TPO
Peer educator networks for diabetes	Cambodia	Maurits van Pelt	MoPoTsyo
Harm reduction in a muslim community	China	Caroline Fitzwarryne	consultant

Title *(click on the title for a hyperlink to the relevant section in the document)*	**Country**	**Author names**	**Affiliation**
Creating synergies in horizontal and vertical funding streams	DRC	Remco van der Veen	CordAid
Performance-based financing	DRC	Remco van der Veen	CordAid
Building on the momentum of local initiatives	Guinea (Liberia, Sierra Leone)	Natasha Howard Mark I Chen Matthias Borchert Anna von Roenne Sarah Kollie Yaya Souare	LSHTM GTZ RHG
A community-centred approach to MCH for remote and under-serviced areas	Haiti	Bette Gebrian Judy Lewis	Haitian Health Foundation / University of Connecticut School of Medicine
Decision Linked Research: Building capacity at the local level to improve Reproductive Health in Transition	Liberia	Molly Fitzgerald Basia Tomczyk	JSI Research & Training Institute CDC
Taking advantage of a post-conflict context to update and scale up treatment policies	Liberia	Caroline Lynch Dr Joel Jones Yah Zolia	Liberian National Malaria Control Programme
Supporting the government in providing primary health care services	Mozambique	Emily deRiel	Health Alliance International
Approaches to service delivery in a context of armed conflict	Nepal	Sudip Pokhrel Friedeger Stierle Kaushal Kishor Singh	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) mbH
Inter-agency health and nutrition evaluations as a tool to improve accountability	Nepal, Zambia, Pakistan, Chad, Burundi, Liberia	Olga Bornemisza Egbert Sondorp Andre Griekspoor Nadine Ezard	LSHTM WHO UNHCR
Voucher schemes targeting populations at risk	Nicaragua	Anna Gorter	Central American Health Institute
Decentralisation	Nigeria	Emmanuel Sokpo Andrew McKenzie Kwame Adogboba	Health Partners International Health Partners Ghana (for PATHS)
Developing Planning and Budgeting Systems	Nigeria	Christopher Allison Kolawole Maxwell Andrew McKenzie	HLSP (for PATHS) Health Partners International
Drug revolving fund	Nigeria	Monday Egume Caroline Vanderick Andrew McKenzie	Grid Consulting Health Partners International (for PATHS)
Improving service delivery through supervision, appraisal, planning and community participation	Nigeria	William Anyebe Andrew McKenzie	Treeshades Consulting Health Partners International (for PATHS)

Title ***(click on the title for a hyperlink to the relevant section in the document)***	**Country**	**Author names**	**Affiliation**
Increasing demand for reproductive health services	Nigeria	Cathy Green Andrew McKenzie Mini Soyoola	Health Partners International (for PATHS)
Strengthening voice and accountability	Nigeria	Cathy Green Andrew McKenzie	Health Partners International
Ensuring quality and sustainability of hospital services in contexts of political instability by forming a hospital network	Occupied Palestinian Territories	Tawfiq Nasser Motasem Hamdan Katja Schemionek	East Jerusalem Hospital Network WHO
Using RED as a foundation for health services delivery in remote and poorly accessible regions	Papua New Guinea	Caroline Fitzwarryne	Consultant
Community Case Management for infectious diseases	Rwanda, Sierra Leone, Southern Sudan	Emmanuel D'Harcourt Debbie Landis	International Rescue Committee
An Essential Package of Health Services	Somalia	Nigel Pearson Austen Davis	consultant Unicef
Independent Service Authorities for service delivery in fragile states	Somalia	Stig Jarle Hansen Bjarne Garden	Norwegian Institute of Urban and Regional Research Norad
Integrating nutrition into routine services provision	Somalia	Nigel Pearson	Consultant
NGOs working alongside the MoH towards HSS	Southern Sudan	Sarah Petrie Kate Hutton	Medair Tearfund
Private-to-public transition model	Southern Sudan	Chris Lewis	Consultant
Factors for scale up and sustainability of a Revolving Drug Fund	Sudan	Nichola Cadge	Save the Children UK
Public-private partnerships for the local production of essential drugs and supplies	Sudan	Omar Taha	NutriSet
Effective management and leadership during a period of crisis	Timor Leste	Anthony Zwi Joao Martins	University of New South Wales
NGOs providing supportive supervision in government facilities	Timor Leste Côte d'Ivoire	Emily deRiel	Health Alliance International
Provision of family planning services through the private sector	Yemen	Louise Lee-Jones	Marie Stopes International
Vitamin A supplementation during Child Health Days	Zimbabwe DRC	Shawn K. Baker Jennifer Nielsen Dora Panagides Sophie Cowppli-Bony	Helen Keller International
The role of NGOs in transition	Unspecified	Derick Brinkerhoff	RTI International for Health Systems 20/20 Project
Coordinating the planning of activities through the MoH	Unspecified	Emily deRiel	Health Alliance International
Social marketing of treatment and preventive measures	Unspecified	Cecilia Kwak	Population Services International
Establishing a common research agenda	Unspecified	Fiona Perry	Tearfund

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