



Health financing in post-conflict settings – a literature review

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Objectives of study

This literature review was carried out in March-August 2011. The objective was to carry out an analysis of thinking, approaches, themes and findings of recent writing on health financing in post-conflict or fragile health systems. This will inform and serve as a baseline for the work of REBUILD, a research consortium contributing to health systems research in post-conflict areas, with a particular emphasis on health financing and human resources. It is a companion piece to a similar literature review on human resources in post-conflict settings, and to the country situation analyses, which synthesise existing literature on the four focal countries for REBUILD (Zimbabwe, Sierra Leone, northern Uganda and Cambodia).

Study methods and scope

Studies from the past decade (2001-2011) were sought, using the following search terms:

Any of the following terms: conflict, post-conflict, reconstruction, fragile

AND: Health

AND any of the following subject terms: financing, systems, performance, research, user fees, exemptions, budgeting, equity, access, performance-based funding, output-based, pay for performance, incentives, resource allocation, public expenditure, contracting, public/private, global health initiatives, aid.

Search sites included the following:

1) general sites, such as:

- Google scholar
- PubMed
- Science Direct

2) databases such as:

- Cochrane database (Effective Practice and Organisation of Care Group)

3) institutional websites which were thought particularly relevant to this topic, i.e.:

- WHO
- World Bank
- Health and fragile states network
- KIT, Amsterdam

We also checked references from included studies to identify other studies that meet the inclusion criteria.

During screening of studies, certain categories were excluded:

- Publications focussing purely on conflict periods, humanitarian responses, disasters, and emergencies
- Publications focussing purely on health systems post-conflict (without dealing with health financing aspects)
- Health service delivery post-conflict (without health financing aspects)
- Studies dealing with health financing but without framing it within the context of post-conflict or fragile health systems

Overview of included studies

A total of 40 main studies were found to be relevant after screening and were included in this review. The subject appears to have gained momentum towards the end of the decade (see Figure 1), although remaining at a relatively small number of publications in total. Of the 40, 30 were peer-reviewed journal articles, and the remainder reports.

Figure 1 Selected publications, by date

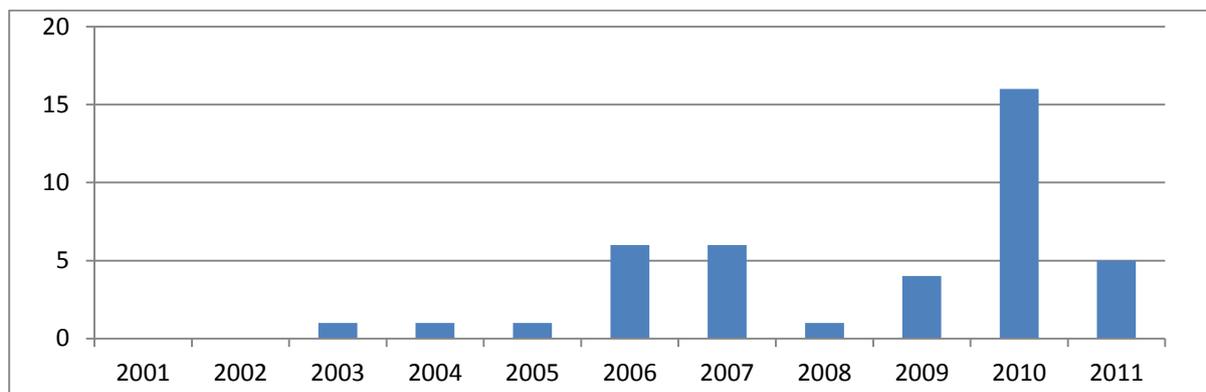


Table 1 Study countries

General	15
Cambodia	6
Afghanistan	7
Sierra Leone	5
DR Congo	4
South Sudan	5
Kosovo	3
Timor Leste	3
Liberia	3
Uganda	2
Rwanda	2
Bosnia	1
Burundi	1
Palestine	1

A summary is presented in Annexe 1. A number of the publications are general or cover a range of countries (**Error! Reference source not found.**). Where they focus on specific countries, the most commonly studied countries are Cambodia, Afghanistan and Sierra Leone. This selection reflects a range of factors, including the countries in post-crisis and conflict during this period, and the focal areas for donor involvement.

Table 2 Studies included, by context definition

A variety of definitions were used in the studies to categorise the contexts (Table 2). The most common one was 'fragile countries' (the meaning of these terms is discussed below), followed by post-conflict countries, but there were other terms too, including countries affected by conflict, disrupted health sectors (health sectors 'in crisis'), countries undergoing social transition, and complex environments.

Fragile	15
General	11
Post-conflict	9
Affected by conflict	4
Disrupted/in crisis	2
Social transition	1
Complex environments	1
Humanitarian	1

Table 3 Included studies, by main theme

Main themes		
Aid effectiveness, donor engagement, aid coordination	11	In relation to the main themes of the studies, the role of donors dominates (perhaps not surprisingly, given the need for external investment, but also the capacity constraints). Of the publications, 14 were focussed on aid tracking, aid coordination, strategies for donor investment, aid effectiveness and global health initiatives (
Health policy analysis	5	
User fees	5	
State building/reconstruction	5	
Equity	3	
Health equity funds/vouchers	3	
Service availability/basic package	3	
Pay for performance	2	
Utilisation barriers	2	
Aid tracking	2	
Non-state actors	2	
Contracting	1	
Community-based health insurance	1	
Health systems analysis	1	
Knowledge translation	1	
Human resources & pay	1	
Research	1	
Global health initiatives	1	

Table 3). These topics are followed in popularity by health policy analysis, the role of user fees, and post-conflict reconstruction and state-building.

Table 4 Studies included, by research methods

An overview of research methods (Table 4) reveals a mix of approaches, biased towards methods which are perhaps easier to carry out in unstable contexts – literature reviews and commentaries are the most common methods, complemented by some studies based on interviews, and also participant observation. Quite a few had methods which were not described and not easy to discern.

Only eight publications identified further areas for research.

In relation to the main organisations supporting these publications and the publication outlets, these were very varied, with no particular dominance by one research group or one journal (see annexe 1).

The structure of the report is as follows:

1. The literature review starts by examining some background topics which are relevant, including the definitions used for core terms and the rationale for focussing on fragile and post-conflict states.
2. It then reviews discussions on health systems development in these states and views on priority areas for intervention, to set health financing in context.
3. There is also a growing body of work on the links between health sector development and state building in fragile contexts, which forms the third section.
4. As a substantial focus in the health financing literature links to aid effectiveness questions, this is reviewed next.
5. Finally, literature on more narrowly focussed health financing questions is reviewed, starting with topics related to revenue generation, then resource allocation, purchasing and service provision.

Research methods/study type	
Literature review only	7
Review/commentary/opinion piece	5
Literature reviews and interviews	5
Not stated and unclear	4
Literature review and participant observation	3
Analysis of secondary data only	3
Secondary data, combined with qualitative research	2
Case studies (undescribed)	2
Qualitative methods only	1
Policy statement	1
Training manual	1
Literature review and 'mixed methods'	1
Household survey and facility survey (one county)	1
Household survey (national)	1
Household survey, health facility survey, & qualitative research	1
Personal reflections	1
Microsimulation	1
Secondary data, literature review, & interviews	1
Secondary data, literature reviews, participant observation	1

Definitions

The majority of publications focussed on 'fragile states', which were defined in a variety of ways¹.

¹ A thorough review of agency definitions of fragile states is contained in the KIT fragile states bibliography (Canavan.A. & Vergeer 2008).

According to DFID, fragile states have governments that cannot or will not deliver core functions to the majority of its people, including the poor. They lack the will and/or the capacity to manage public resources, deliver basic services and protect and support poor and vulnerable groups (DFID 2005).

The DAC Fragile States Group employs a concept of fragile states as suffering 'deficits in governance' creating 'conditions that make development difficult'. In such states (OECD 2005) there is a lack of ability or willingness to establish preconditions for long-term development, the underlying political and economic conditions are too fluid and too risky to encourage savings and long-term investment, and there is a tendency for communities and individuals to focus on the near term and securing basic needs.

Others focus on the concept of resilience. A fragile state is one that lacks some or all of the characteristics of a resilient state (Eldon, Waddington, & Hadi 2008). The term resilience is used to mean the ability of states to withstand and adapt to stress in ways that maintain a 'creative relationship' between state and society. Together, capacity, institutions, legitimacy, resources and effective processes to support a social compact combine to produce 'resilience'. Some states without a strong state-society compact may be able to recover from stress, at least in the short-term. However, if a state has to rely on violence rather than political processes to maintain stability then its legitimacy is at least questionable, and states with weak legitimacy are unlikely to remain resilient in the longer term. They must either adapt to the changing demands of society for a reshaped social compact, or be overtaken by social, economic and political change.

Although there are many descriptions of fragile states, the two components they have in common (Newbrander 2006) are *legitimacy*—government will and capacity to provide core services and basic security—and *effectiveness* in providing services and security. These elements are interrelated in that the lack of capacity or willingness of governments to respond to the basic needs of people—food, water, shelter, sanitation, health, and security—means that people feel betrayed by the government's ineffectiveness and inability to maintain order and provide for their needs. In their eyes, the government lacks legitimacy. Many post-conflict countries demonstrate these conditions of fragility. Fragility can also occur, however, when there is stagnation or chronic underperformance, or it may signify a country's downward spiral from declining performance to collapse of government and civil society to conflict.

It has been noted by some that many countries, including many in Africa, have never had functional government and service delivery systems, so non-functional government and systems have been the norm (Newbrander 2006).

Many development partners have their own list of fragile states based on various parameters, including risk of conflict, accountability of government institutions, capacity to manage public resources and deliver services, territorial control, levels of poverty and ability to protect the poorest. The World Bank (through its Country Policy and Institutional Assessment scores) focuses on economic development; countries with a particularly low CPIA score are defined as Low Income Country Under Stress (LICUS).

There is no universally accepted classification of 'fragile states' (Tayler 2005). There is substantial overlap between the lists, and a core of countries (Afghanistan, Angola, Democratic Republic of Congo, Myanmar, Niger, Nigeria, Somalia and Sudan) that appear on many or all.

The DAC's typology for describing fragile states is: (1) deteriorating state, (2) collapsed state,

and (3) state recovering from conflict. Some analysts further segment the third category into post-conflict and early recovery stages. The categories reflect the fact that conflict is not a requirement for fragility, though there is an overlap (OECD, 2005).

As some authors point out, the fragile states group encompasses very different groupings of countries. It includes countries with repressive governments (Myanmar, Zimbabwe), poor governance (Chad, Nigeria), localized conflict (Indonesia, Nepal, Sri Lanka, Uganda), chronic ethnic unrest (Ethiopia), and economic crisis (Burundi, Tajikistan). In most instances, the various aspects of fragility are intertwined (Pavignani & Colombo 2009).

The World Bank LICUS group have been classified into four typologies: (1) prolonged crisis or impasse (e.g. Myanmar, Somalia, Zimbabwe); (2) post-conflict or political transition (e.g. Democratic Republic of the Congo, Liberia, Southern Sudan); (3) gradual improvement (e.g. Burundi, Cambodia); or (4) deteriorating governance (e.g. Côte d'Ivoire). Each year the lists are revised, so fragility is a status, not a permanent classification (Alliance for Health Policy and Systems Research 2008).

Whilst specifics vary across fragile states, the problems are a combination of ethnic fragmentation, neo-patrimonial politics, over-reliance of the economy on natural resources, conflict and corruption (Tayler 2005). Although there is a group of countries that most observers would confidently classify as “fragile”, there is a much greater number that demonstrate some, but not all of the characteristics of “fragility”. Absolute definitions are not helpful, and how a country is classified will depend upon when and how one looks at it.

Post-conflict is a simpler concept: a country or area is considered to be post-conflict when active conflict ceases and there is a political transformation to a recognized post-conflict government (Canavan, Vergeer, & Bornemisza 2008). The transition to post-conflict status is however not linear, as political settlements often take years, and about 40% of countries collapse back into conflict (Collier & Hoeffler 2004). Poorer countries are more likely to be affected by conflict and are also more likely to relapse into conflict (Kruk et al. 2010).

Moreover, it is recognised that the post-conflict period divides into different stages. The transitions are very complex and context-determined. However, they can be broken down into three broad, sometimes overlapping, phases: emergency and stabilization (0-11 months post-armed conflict); transition and recovery (12-47 months after the cessation of war); and peace and development (4-10 years post-armed conflict) (Ahonsi 2010).

Other terms such as ‘disrupted’, ‘social transition’ and ‘complex environments’ are often used without clear definition. In general, they appear to refer to a variety of ‘complex political emergencies’ or ‘protracted crises’ (Pavignani & Colombo 2009), which largely overlap with the notion of fragile and post-conflict states.

Background: rationale for focus on fragile & post-conflict states

State fragility remains one of the most significant challenges for the well-being of affected populations, progress towards the Millennium Development Goals, and health and development donors (Bornemisza et al. 2010). Fragile states are home to one-sixth of the world’s population, but one-third of those living on less than US\$ 1 per day. These states often face the double challenges of fractured health systems and reduced capacity to absorb external funding. Violence, conflict, corruption, exclusion or discrimination of certain groups, and gender inequalities are also common characteristics.

The greatest burdens in terms of maternal and child health are also found within fragile states (Newbrander 2006):

- More than a third of maternal deaths worldwide occur in a fragile state.
- Half of the children who die before age five live in a fragile state.
- Death rates of more than 1 death per day per 10,000 population occur in fragile states.
- A third of the population of fragile states is malnourished.
- A third of people living with HIV/AIDS are citizens of fragile states.
- Malaria death rates are 13 times greater in fragile states than in other low-income countries.

The 46 states currently defined by DFID as 'fragile' are significantly worse off than non-fragile states in terms of key health and social determinants of health indicators. In addition, half of these states (23 countries) are conflict-affected. Analysis has revealed that conflict-affected fragile states are significantly worse off in comparison with non conflict-affected fragile states (Ranson et al. 2007). The national health system is also a victim of conflict, with destruction of clinic and hospital infrastructure, the flight of health professionals, and the interruption of drugs and other medical supplies (Kruk, Freedman, Anglin, & Waldman 2010).

The international community is concerned about fragile states for several reasons, including the magnitude of the problems which they present, but also a concern about their potential to spread instability (Newbrander 2006). For example, state collapse can threaten regional security and development. Fragile states are sources of mass outmigration. They may be repositories for international crime. They may breed terrorism. They affect the global economy. They are repositories of disease (Newbrander, Waldman, & Shepherd-Banigan 2011).

Aid to fragile states has been increasing but remains low compared to non-fragile states. A recent study that analysed aid to fragile states between 1992 and 2002 found that controlling for population, poverty and performance, fragile states receive around 40% less aid than predicted (Dollar & Levin, 2005 in (Alliance for Health Policy and Systems Research 2008). Investing in fragile states is viewed as more costly and more risky, but essential for the health MDGs (High level forum on the health MDGs 2005). Much of the investment has also had a strategic focus: for example, the United States has spent \$49 billion dollars for Iraq reconstruction overall since 2003 and other global donors have contributed an additional \$17 billion (Kruk, Freedman, Anglin, & Waldman 2010).

Health systems development in fragile states

In fragile states, the health system building blocks are by definition weak and incomplete – they were either never fully functional or they have suffered from a period of neglect and decay (Eldon, Waddington, & Hadi 2008). Characteristics of fragile health systems are said to include the following (Newbrander, Waldman, & Shepherd-Banigan 2011):

- inability to provide health services to a large proportion of the population outside urban areas;
- ineffective or nonexistent referral systems for the critically ill;
- a lack of infrastructure (including facilities, human resources, equipment and supplies, and medicines) for delivering health services—what did exist has been destroyed or severely compromised due to war and/or neglect;
- nonexistent or inadequate capacity-building mechanisms and systems, such as national clinical training programmes, to address the dearth of clinical and management capacity;
- insufficient coordination, oversight and monitoring of health services by the emerging government, which may not have the capacity to manage;
- a lack of equity in who receives the available health services: few public health services exist for the poor and in rural areas;

- a lack of policy mechanisms for developing, establishing and implementing national health policies;
- non-operational health information systems for planning, management and disease surveillance; and
- inadequate management capacity and systems (such as budgeting, accounting and human resource management systems) for controlling resources.

These define the challenges for health system development or strengthening. Effectively, fragile states face the same challenges as all resource-constrained contexts, only to a greater degree (Canavan & Swai 2008;Commins 2010).

In relation to equity, paradoxically, equity may be improved within conflict-affected countries because of a levelling down effect – many people (except for the few who profit from the war) may become worse off in comparison to non conflict-affected countries or pre-conflict baselines, and differences between different social strata may become less pronounced. On the other hand, the differential between the most well-off and the least well-off may increase substantially, thus increasing inequity. For instance, in some conflicts the intensity of fighting varies between regions resulting in differential impacts by geographic area. As a result, some subpopulations suffer dramatic declines in health, and there is an increasing equity gap, both within the country, and in comparison with other countries (Ranson, Poletti, Bornemisza, & Sondorp 2007).

Health systems strengthening is, essentially, state-building at the sectoral level. This is different from strengthening health services, which does not have the same connotations of a whole system and the role of the state. Not all activities in the health sector contribute to state-building or health systems strengthening (Eldon, Waddington, & Hadi 2008).

Health systems and state-building

There is a growing interest in the extent to which health system development can contribute to state-building in fragile states. State-building is defined as the process of strengthening state institutions and promoting state legitimacy to establish the foundation for a resilient state (Eldon, Waddington, & Hadi 2008). The hypothesis is that building health systems contributes to wider state-building by helping to strengthen state capacity and by signalling the increased willingness of the state to act on behalf of citizens in a responsive and accountable manner. This generates enhanced support for the state in return (legitimacy) and a stronger social compact between state and society. Furthermore, the planning, management and delivery of health services throughout a state is inherently interdisciplinary and contributes to capacity development beyond the health sector (Eldon, Waddington, & Hadi 2008).

These expectations are echoed by other writers – for example, Newbrander, who argues that health services can be an entry point for engagement with government and civil society; that health services are one element of the “peace dividend” in post-conflict countries; that good health service delivery enables government to be effective and increase its legitimacy; and that health services can help break the vicious cycle in which fragility causes poor health indicators and poor health can be a cause of fragility (Newbrander 2006). In a similar vein, Kruk et al. propose that ‘careful design of the core elements of the health system by national governments and their development partners can promote reliable provision of essential health services while demonstrating a commitment to equity, strengthening government accountability to citizens, and building the capacity of government to manage core social programs’ (Kruk, Freedman, Anglin, & Waldman 2010).

A review of the evidence (Eldon, Waddington, & Hadi 2008) hypothesised that that some, though not all, health sector activities in fragile states contribute to health systems strengthening by:

- building state capacity in stewardship, support systems, institutions and policy;
- signalling increased willingness of the state to act positively on behalf of citizens
- helping to strengthen the legitimacy of state institutions and improving citizen trust in the state;
- helping to clarify citizens’ expectations of the state, and vice-versa, and
- making these expectations more realistic and manageable, thereby
- strengthening the social compact around health; and
- improving resource management.

Further, some health system strengthening activities may have a wider state-building role beyond the health sector by:

- strengthening the capacity of other institutions and sectors;
- strengthening citizen interactions at different levels of the state;
- encouraging citizen involvement in public life; and
- over the long-term improving health outcomes, which reduces poverty and thus the risk of conflict

The review found the evidence was inconclusive. There may be more scope for wider state-building and strengthening the state-society compact through decentralised and ‘bottom up’ approaches, though this needs to be verified through systematic study.

The evidence from Sierra Leone suggested a link between the provision of good quality health services and community perceptions of the state, although this would need to be empirically tested. Immediately after the war, perceptions of the state appear to have risen as the Government of Sierra Leone, with donor support, made rapid progress in improving key services. More recently, support for government appeared to be falling, among other things because some services were

stagnating or completely failing. The decline in government popularity was tangible, although since the 2007 elections people seemed willing to give the new administration a chance to make improvements (Eldon, Waddington, & Hadi 2008).

The authors observe that the Ministry of Health is often a rather low-status ministry in fragile states. It tends to be relatively weak politically, institutionally and financially, with insufficient authority for wider state-building (Eldon, Waddington, & Hadi 2008). Moreover, health seems to be more a pre-occupation of the international community than of governments in fragile states.

Other groups highlight other outstanding questions, including the reverse question of how poor governance, conflict and the tendency to recidivism affect health sector rebuilding and health systems strengthening, for example (Alliance for Health Policy and Systems Research 2008).

There is a growing interest in the role of health systems as social institutions (Kruk, Freedman, Anglin, & Waldman 2010). One line of this work focuses on how the design of a health system, and particularly its financing, conveys important social and political values of the state. For example, the levying of user fees that are beyond the means of the poorest legitimizes the exclusion of some portion of the population on the basis of ability to pay. Conversely, a financing system that employs cross-subsidization mechanisms to work toward universal access, and builds public support for such mechanisms, communicates the importance of social solidarity. In establishing post-conflict health services, particular attention should be paid to addressing pre-conflict inequities and to providing services to individuals most vulnerable during conflict (Pavignani 2005). In Mozambique, initial health system reconstruction efforts were focused on underserved and rural communities, as well as in areas controlled by the resistance party. These efforts relieved tensions and demonstrated the government's commitment to reintegration (Vaux & Visman 2005). More fundamentally, governments can embed access to health care as a right of citizenship in new constitutions, as happened recently in Nepal (Witter et al. 2011).

There can be a tension between the role of donors in responding effectively to post-conflict needs and the development of the role and capacity of government (Rowley, Altaras, & Huff 2006). Where there are conflict-affected regions within otherwise stable countries, as was the case in Uganda, a pattern of government service provision in stable areas and donor-supported services in conflict-affected regions can undermine government legitimacy, creating a perception of marginalised populations (Rowley, Altaras, & Huff 2006). This raises the importance of donors fostering government stewardship, involving government personnel in activities, giving visibility to public programmes, and passing control over resources to government. There is little documented evidence that suggests a donor focus on improving stewardship in fragile states (Eldon, Waddington, & Hadi 2008).

In addition, some suggest that donors should put more focus on the demand side, looking for opportunities to support the provision and dissemination of information, to work with civil society and professional groups that are trying to improve service quality and accountability, and with those working on participatory monitoring and budgeting and other "tools of accountability" (Tayler 2005).

Engaging with the policy making process in fragile/post-conflict states – quagmire or window?

A number of case studies discuss the role of donors in relation to policy-making post-crisis. Most, focussing on the immediate post-crisis period, take a pessimistic tone. The more the government is insecure and hesitant about the direction to take, the more likely there will be a proliferation of policy proposals. Many of them may even be endorsed, without being enforced. Unstable, “mosaic” policymaking is often the prevailing feature, with alliances of actors converging on specific policy issues possessing special appeal at a given point in time, to dissolve quickly as their attention is captured by other concerns. The quick turnover of actors and the fast-evolving environment make this process of clustering and dispersion of efforts erratic and turbulent (Pavignani & Colombo 2009).

During protracted crises, virtually all factors conspire against effective policymaking (Pavignani & Colombo 2009). The state authority is contested, top managers are removed from their posts or move to other jobs, the public sector is crippled, instability and uncertainty discourage long-term initiatives, the information base is poor, actors multiply and are replaced, memory is weak, the policy discussion easily takes political overtones, and accountability and transparency are difficult to enforce.

A case study of Kosovo found that external actors drove the health reform process; that the policies selected reflected the objectives of the international community; that donors believed reform could be achieved in a compressed time period, and gave more priority to the design than the implementation of reforms; that state capacity in the post-conflict period was low, and that external actors did not recognize the importance of state capacity in health reform (Percival & Sondorp 2010). Capacity was further undermined by the post-conflict political context. The health system was an important arena for political struggle.

There is thus a recognised potential conflict between using the ‘window’ to modernise systems and introduce major reforms and establishing more local involvement and ownership. These models can sometimes be too dramatic and foreign (e.g. introducing a Swiss cantonal model into Bosnia post-conflict) (De Vries & Klazinga 2006). It is particularly challenging when there is no recognised local authority in place, as was the case in Kosovo. Here donors followed their traditional paradigms and were reluctant to fund recurrent expenditure, perhaps not fully recognising that in Kosovo, the international community was the government (Shuey et al. 2003). While contributing to reform of the sector, there was limited local ownership and a lack of direction regarding the appropriate mix of public and private funding and provision of health care, thus opening the way to possible future imbalances and inequities which may prove difficult to control (Shuey, Qosaj, Shouten, & Zwi 2003).

Aid and aid effectiveness

Literature on post-conflict and fragile states is dominated by discussion of the role of donors, of how to coordinate aid, and of how to maximise aid effectiveness.

Managing the transition from humanitarian aid

There is a consensus that donors can and should have a two-prong approach in the immediate post-conflict period that addresses humanitarian and health system needs (Newbrander, Waldman, & Shepherd-Banigan 2011). In Liberia, the government, donors and health partners worked together to coordinate in the post-conflict period of 2006–09. They had a dual focus on maintaining access to care and rebuilding the health system. Donors continued to fund humanitarian assistance partners

to provide basic services for several years after the conflict had ended. This continuity gave the Ministry of Health and Social Welfare (MOHSW) the opportunity to concentrate on coordinating system-strengthening activities such as developing national pre- and in-service training programmes and instituting a facility accreditation process. This window of opportunity also provided time for development donors and partners to work with the MOHSW to design projects that met national long-term strategic objectives (Newbrander, Waldman, & Shepherd-Banigan 2011).

In relation to concerns about funding gaps as countries were transferred from humanitarian to development aid tracks, one study found that of the six settings analysed, two experienced no funding gaps (Afghanistan and Timor Leste), three had probable funding gaps (DRC, Southern Sudan and Sierra Leone), and one averted a funding gap (Liberia) (Canavan, Vergeer, & Bornemisza 2008). In Afghanistan, the findings suggest that there was no discernible gap in funding during the transition from humanitarian to development aid, and that development aid now eclipsed humanitarian aid over five years into the transition. Political will and strong donor leadership were highlighted as key to the rapid scale-up of development funding for basic services delivered through the contracting-out to NGOs. In Timor Leste, no transitional funding gap affecting the delivery of health services after the conflict was observed. A 2005 Mid Term Expenditure Framework (MTEF) revealed that the total funding to the health sector had been increasing over the past ten years. While a reduction in donor aid was anticipated, government funds were expected to increase due to Timor Leste's available oil revenues.

In contrast, findings from the DRC suggested that a transition gap existed (Canavan, Vergeer, & Bornemisza 2008). A World Bank Public Expenditure Review revealed a steady increase in development funds from 2003–2007, but a marked decline in humanitarian funding, which had led to a transitional funding gap. A fall in humanitarian funding (2006-07) had led to the abrupt withdrawal of some humanitarian NGOs, resulting in reduced health service delivery. DRC's complex aid instruments, coupled with geographic stratifications by donor, also challenge the achievement of optimal coverage and coordinated approaches to health service delivery; an estimated 83 out of 515 health zones had no external financial support.

In Sierra Leone, it was not possible to determine if there was a transitional funding gap due to the difficulty of obtaining reliable information. Sierra Leone had witnessed a downsizing of humanitarian support to health services following the peace agreement in 2002, while key informants reported that development funds were slow to arrive. The exit of a number of international NGOs due to lack of funding suggested that there may have been a funding gap (Canavan, Vergeer, & Bornemisza 2008). In Southern Sudan, it was also not possible to obtain comprehensive funding trends. However, delays in the disbursement of the Multi-donor Trust Fund (MDTF), which accounted for 43% of total funding, were indicative of a funding gap. Donors such as the Office of US Foreign Disaster Assistance (OFDA), which supported over 50% of health services provided by NGOs, had extended humanitarian aid to try to fill the gap and sustain services for rural populations. Finally, in Liberia, aid flow information revealed that there was no transitional funding gap. In 2006, a funding gap was a very strong threat, with humanitarian donors starting to leave the country and development funding slow to arrive. However, due to the recognition by both the Ministry of Health and the NGOs, significant pressure, backed up by detailed analysis and projections, was put on the donors at the Washington Donors Conference in February 2007. Consequently, humanitarian donors agreed to continue to fund basic health services until the situation stabilized and the gap was averted.

Overall, the study found that it is not the choice of an aid mechanism used in the transition from relief to development but rather the flexibility to adapt it, or the mix and sequencing of aid mechanisms that influence transitional funding flows (Canavan, Vergeer, & Bornemisza 2008). Government capacity and legitimacy play a major role in how quickly development funding flows

into a country and humanitarian funding is withdrawn. NGOs are influential in terms of highlighting gaps, and in mobilizing resources to fill them. Overall, donor representatives and independent experts felt that the main issue in many post-conflict contexts was not the transitional funding gap *per se*, but rather lack of donor harmonization, a tendency towards aid volatility, and limited alignment to national governments.

Lessons on good practices for aid in fragile & post-conflict settings

Donors invest in health for a range of reasons: sometimes for immediate gains in mortality and morbidity (reflected in the current focus on the MDGs), sometimes in the hope of developing a more sustainable and effective health system, and sometimes as a part of a broader agenda of improving the stability, governance and economic performance of a country (Tayler 2005). Each of these represents different objectives for development assistance and each may require different sets of aid strategies and instruments.

Based on a review of case studies, some key lessons are proposed for donors intervening in fragile states' health systems (Newbrander 2006). They emphasise the need for long term commitment, but also flexibility:

Strategy:

- Seek to impact the lives of those in need
- Build the capacity of government and non-state providers
- Promote equity
- Consider sustainability in the light of state fragility
- Recognize changes in the environment and adapt accordingly (flexibility)
- Promote transparency and accountability

Engagement:

- Provide long-term expert presence on the ground
- Staff must have experience and a wide range of technical skills
- Staff need to be held accountable

Financing:

- Provide reliability by committing to long-term financing
- Ensure flexibility in financing from relief to transition to development
- Be willing to cover recurrent costs
- Ensure equity concerns are met before financing

Implementation:

- Start with basic package of health services and expand the range of services over time
- Promote system development
- Make evidence-based decisions
- Monitor performance

Long term commitments

Concerns about inequitable and volatile aid flows to fragile states are raised as key concerns (Canavan.A. & Vergeer 2008). Aid flows should better reflect population needs, and donors should commit to 10-15 year time frames (Ranson, Poletti, Bornemisza, & Sondorp 2007; Rubenstein 2011). The OECD-DAC's twelve 'principles for good international engagement in fragile states' (OECD 2005) suggest that donors should engage more quickly, and for a longer period of time in fragile states. In practice, however, most donor projects have a life between zero and three years, so there is little knowledge of donor funds more than a year ahead (Eldon, Waddington, & Hadi 2008).

A shift in the meaning assigned to sustainability is imposed in the context of failed states, severe poverty and increased health needs, such as in the Democratic Republic of the Congo and Afghanistan. For protracted periods (most likely decades), these countries will be unable to survive by relying only on their own means. A “sustainable” health service must therefore be intended as an activity guaranteed on an uninterrupted basis, even if financed by external resources. Rather than downplaying performing health services provided to a population in need of them, on the sole basis of their external sources of funding, the scrutiny should shift from this dimension to the predictability of such funding and to the possible strings attached (Pavignani & Colombo 2009).

Taylor (2005) argues that whatever approach is adopted, donors need to be realistic about sustainability. They should plan and finance over long time frames – whilst also allowing for frequent reviews, built-in flexibility and scope for redesign. Even where there is not an absolute shortage of resources, financial flows may be difficult, and if donors want to make a real difference they should be open to paying recurrent costs and supplementing salaries..

Speed and flexibility

In South Sudan, the Multi-Donor Trust Fund was slow in setting-up and disbursing funds, and this meant that for effective delivery of interventions in the post-conflict recovery phase the country remained reliant on humanitarian financing channels (Cometto, Fritsche, & Sondorp 2010). These authors argue that donors should maintain flexibility in channelling their support to the financing mechanisms that are proven to provide the best trade-off between effectiveness in expanding service coverage and in building the capacity of nascent government authorities. In southern Sudan, no funding mechanism had struck the right balance, according to the study authors.

However, speed of engagement has its own risks. In post-conflict situations, international agencies can prematurely put pressure on national governments to formulate comprehensive health policies before capacity and information are in place, as Pavignani and Colombo (2009) describe in relation to Kosovo, Liberia and Angola. Donors’ agendas in fragile states are littered with “quick win” or “early start” projects that are still foundering several years after inception (Taylor 2005).

In a ‘disrupted’ sector and state, one-off technical assistance activities may be less useful than incremental institutional capacity building. Based on experience in developing a human resource development plan in southern Sudan in 2005-6, some authors question assumptions underlying technical assistance, including that policies and plans must be put in place swiftly and that lack of information is a key barrier to good decision-making (Beesley, Cometto, & Pavignani 2011). Technical assistance can end up producing a deluge of information which local institutions do not have the capacity or interest to use, and which is quickly out of date. This competition for influence on nascent health authorities, and the inconsistent actions it generates, is another common trait of post-conflict processes. After being established, institutions are very much focussed on internal goals: in this transition phase, the attention of most Ministry of Health officials was likely to be attracted to issues internal to the institution at central level, such as power, funding, prestige, perks and working tools. Competing goals, risk avoidance and non-action, detours, trade-offs, reversals and the divergence between documents and actions are among the hallmarks of real-life health policy and planning processes.

Donor policy on post-conflict health reconstruction typically has been viewed through the lens of security and stabilisation, whose priorities are increased security for the population, demobilisation of former combatants and the establishment of effective policing, good governance, the rule of law, and the creation of jobs (Rubenstein 2011). However, evidence for the effectiveness of this is limited and it has risks (e.g. the association of health workers with a particular political group). A second concern with the stabilisation basis for policy is that it may well discount or discard key principles of

participation, equity and non-discrimination, and encourage services which are not sustainable. For instance, Provincial Reconstruction Teams in Afghanistan are designed to be 'opportunistic and idiosyncratic', concentrating on achieving immediate results. In other settings, 'state avoidance' by donors can create a preponderance of vertical funding, which will later be challenging to integrate (Alliance for Health Policy and Systems Research 2008).

Reinforcing government stewardship and capacity

Aid coordination mechanisms should reinforce and not compete with government structures. Indeed, the need to reinforce government capacity and stewardship is a theme of most studies. Even if most governments cannot provide a full range of services, Kruk, Freedman, Anglin, & Waldman (2010) argue that they should be supported to set policy, regulate the market and contract services. (Rubenstein 2011) argues that health systems development should drive funding mechanisms for health reconstruction, not, as so often happens, the other way around.

Experience over recent years has shown that much capacity-building has been limited in coverage, 'projectised', fragmented, donor-driven and unpredictable. The approach to capacity building has been more ad hoc and short-term in nature. It is also un-coordinated and often builds the capacity of individuals rather than (re)building the functions of the health system for the longer term. As a result, little knowledge and skills have been sustainably transferred to local counterparts and changes to institutional capacity have been slow (Rothman et al. 2011).

All the analysis suggests that the absorptive capacity of government systems in fragile states is initially very low, and the prime need is for excellent technical assistance in core areas such as policy development and basic systems (Tayler 2005). Contractual type relationships are probably not the answer for relations with government. The international financing institutions have developed huge experience of "conditionality" over the last few decades, and there is an emerging consensus that enforced conditionality is rarely effective.

Addressing governance challenges is central to most development partners, and stewardship in the health sector is a key element of this. In Sierra Leone, the Reproductive and Child Health Programme (RCHP) was a large multi-donor programme focusing on MDGs 4, 5 and 6, and represented an attempt by all the main donors to focus their efforts around one national plan. When operationalised, the RCHP could make a major contribution to improved governance in the health sector (Eldon, Waddington, & Hadi 2008). In Rwanda, strong government leadership and coordinated action to streamline aid management processes, address demand barriers and motivate providers were seen as key contributing factors to the recent improvements in health indicators (Logie, Rowson, & Ndagije 2008).

In many fragile states the problem is not that a system does not exist, but rather that it is over complex, and made more dysfunctional by multiple attempts to bypass and repair it (Tayler 2005). Donors' capacity to act and to spend their money effectively may be constrained by the complexities of government systems, and by the need to intervene in multiple areas and at multiple levels in order to make a difference. Very often actually understanding the system may be a major challenge, since, particularly in fragile states, the realities and the formal rules of the health system can diverge significantly.

With the advent of decentralisation, planning and management functions for health service delivery have (or are beginning to) shift towards local councils at peripheral administrative levels (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). This growing autonomy requires new structures and systems that can accommodate the transfer of responsibilities and resources. District authorities often possess a limited understanding of aid architecture, resource flows and the criteria for

monitoring and managing aid efficiently and effectively. The proliferation of NGOs, donors and private actors operating at service delivery levels (in light of the weak capacity of sub-national authorities) undermines coordinated strategic dialogue and information sharing. The introduction of district level planning in Sierra Leone has demonstrated the potential for improving communication and coordination among actors at the sub-national level if there is strong leadership within the district, and sustained financial and technical resources to district authorities.

Working in fragile states is intrinsically a high-risk activity. Donors need to acknowledge this, get much better at assessing and managing risk and avoid being deflected and over influenced by short term setbacks. The expectations of politicians and the domestic audience need to be appropriately managed (Tayler 2005). Understanding what is going on and why is difficult. Donors wanting to make a quick impact may assume that there is not much going on, or decide to bypass the existing system and set up something new. This is usually a mistake. The established system will continue to consume energies and resources. Fragmenting a system probably decreases the chances of any part of it working properly, and the new system may undermine existing forms of service delivery. It is far better to try to work out what there is, and focus as much on the “why services are still continuing” as on why things are not happening. Identifying and harnessing existing incentives is likely to be more efficient and sustainable.

Alignment and harmonisation

As part of efforts to increase aid effectiveness there is a general trend towards increasing alignment with countries’ priorities and working through government systems. Most agencies still feel that for political and programmatic reasons this is not realistic in fragile states, but there have been notable exceptions: DFID provided budget support to the Sierra Leone government; countries such as Nepal, Yemen and Papua New Guinea are moving towards sector-wide approaches, and some countries – such as Uganda and Mozambique - moved relatively rapidly from post conflict to budget support (Tayler 2005).

A vital lesson from post-conflict settings is the need for early development of an overarching policy framework to overcome the fragmentation and verticalisation typical of the humanitarian phase (Pavignani, 2005). Wherever possible donors should support the core stewardship functions - helping national governments to lead the development of a coherent and realistic health strategy, and to co-ordinate the various stakeholders (Tayler 2005). Between 2007 and 2008, the Ministry of Planning in DRC counted 247 different projects used by 20 donors to channel aid. 187 projects were set up by only four donors (Belgium, the EC, the UN and the World Bank) (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011).

Even if full alignment is not possible, or formal structures are not yet established, then working alongside government systems, respecting factors such as geographical boundaries, systems and reporting time frames, is a supportive and in the long run potentially more sustainable way forward. Donors should harmonise their inputs, sharing reporting and procurement requirements, and where possible developing common approaches to implementation. In post conflict Uganda donors divided the districts among themselves, and then worked in quite different ways, which posed a real challenge for the government. Something similar is currently happening in Afghanistan, where donors have each taken responsibility for a part of the country, and while they are all developing contracting schemes, they are using different approaches and models (Tayler 2005).

Where a government lacks the will to coordinate donors or work with NGOs, and is not developing a health strategy, donors should still harmonise their policies systems and activities. Where possible they should try to undertake “shadow alignment” arrangements (Tayler 2005).

The early post-conflict phase in southern Sudan saw the main stakeholders agreeing to a common policy framework formally owned by the Government of South Sudan. The start of recovery activities was slow, with limited progress in the three years after the peace agreement (CPA). The stagnation in health service coverage has been mirrored by only marginal improvements in the governance of the health sector, as testified by the slow pace of implementation and the low budget execution rate of the Multi-Donor Trust Fund. Recovery was speedier in other post-conflict settings (Strong, Wali and Sondorp, 2005). Several factors may explain why the pace of recovery in southern Sudan was slower than in other countries, including limited Ministry of Health capacity, even relative to other post-conflict settings, and inconsistency in providing technical assistance (Cometto, Fritsche, & Sondorp 2010).

Health financing in fragile countries is characterised by top-down financing with little local decision-making; failure to use government financial management channels; few attempts to harmonise donor funding; resource allocation often quite separate from and out of sequence with government plans about tax, insurance and/or user fees; and information on overall funding levels often not collated and analysed (Eldon, Waddington, & Hadi 2008). In Sierra Leone, for example, most donor support has focussed on primary health care. Combined with donor support for decentralized governance and capacity building at district level, the net effect has been positive for state-building at the local level. However, there is little or no integration, and secondary and tertiary health services have all but collapsed (Eldon, Waddington, & Hadi 2008).

Some donors supported the establishment of new departments and units within the ministry primarily to implement 'their' programmes. This can involve the transfer of staff from existing departments into better resourced ones, thereby further undermining overall capacity. The approach can be seen as creating centres of technical excellence or, alternatively, placing cuckoos in the nest (Eldon, Waddington, & Hadi 2008). Pressure on donor staff to spend quickly and deliver on the MDGs appeared to be driving this approach.

Readiness for sector-wide approaches (SWApS)

SWApS may be a useful mechanism for coordinating aid funding but they are hard to achieve, perhaps particularly in fragile states. One study of Timor Leste, Sierra Leone and DRC found weaknesses in relation to each of the six components required to make a SWAp effective (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). These were identified as:

- Government leadership of the sector through sustained partnership
- A clear, nationally-owned sector policy and strategy, derived from broad-based stakeholder consultation and which is supported by all significant funding agencies
- A (medium term) budget and expenditure framework which reflects sector policy
- Shared processes and approaches for planning, implementing and managing sector strategy
- A sector performance framework monitoring against jointly agreed targets
- Commitment to move towards greater reliance on government financial management and accountability systems

All three countries were found to have developed a health sector strategy to guide health sector reform measures over the medium term. All health sector strategies had been developed with strong support by donors. The Health Ministries demonstrated concerted initiative and leadership regarding strategy development and consultation and debate processes. Ownership over resources and implementation by the Ministries of Health was undermined by the fact that most resources were externally financed by development partners whose aid was very fragmented, uncoordinated, off-budget and only partially aligned with government systems and strategies. Although donors paid

lip service to government strategy, their approaches were often not in line with national health sector strategies.

The phenomenon of Program Implementation Units (PIU), which have proliferated with the advent of global fund partnerships and multilateral funding arrangements, were noted as a barrier to embedding financial management systems within government institutions. The hiring of senior government staff at competitive salaries has also created a brain drain effect on the mainstream operations of the health sector (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). Frequent changes in leadership, at both political and technical levels, further challenged sustained development.

Central to sector leadership capacity is the availability of adequately skilled human resources and the presence of appropriate structures and systems necessary for managers and staff to function effectively. All three countries struggled with a severe lack of skilled personnel. The absence of competent staff at middle and peripheral management levels meant that senior management staff members were overwhelmed with both macro and micro management decisions. Transparency and accountability were also found to be weak in all three countries.

Ministries of Health have increasingly taken greater initiative and leadership in strategy development and implementation processes. In all three countries, the costing of sector strategies is generally weak, however. Donors have made a political commitment to align interventions with government strategies. This political commitment, however, has not been implemented as donor financing remains highly fragmented and often vertical with off-budget interventions. Governments have a tendency to accept all donor proposals, even those directly at odds with their policies. Policy coherence of sector strategy with other sub-sector strategies and vertical programmes is poor in all three countries. Many sub-sector strategies are out of date and lack uniform implementation plans. There are 22 different donor alliances in DRC's health sector, 15 in Sierra Leone and 12 in Timor Leste, according to the 2010 aid fragmentation index (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011).

Sierra Leone and Timor Leste are currently working with the basic pillars of a Medium-Term Expenditure Framework. However, information pertaining to both on and off-budget aid is incomplete, irregular and differs across various sources. While sector-specific estimates were unavailable, the Paris Declaration indicators demonstrated that at national levels the share of aid included in government budget estimates was 54% in Sierra Leone and 21% in DRC (for 2007). A limited picture of overall resource availability hampers realistic and predictable strategic planning of sector resources (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011).

There was generally no systematic and comprehensive monitoring of health sector performance in the three countries studied (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). Monitoring was reactive and ad hoc and usually reflects donor requirements. Most health information was project driven rather than acquired through a systematic Monitoring and Evaluation (M&E) framework led by the Ministry of Health. PIUs undertook their own reviews and evaluations and conducted separate data collection and performance reporting. Data collection for national programmes functioned better due to investment by vertical programme donors, while other critical sub-sectors (e.g. Maternal and Child Health) were often neglected. Opportunities for alignment of M&E systems were undermined by vertical programmes that collected monthly data to satisfy their own needs. Information collection through national Health Information Systems (HMIS) was limited and not well understood by district health management teams or health facility managers.

Global health initiatives

Global health partnerships are providing an increasing amount of resources to developing countries to address specific diseases or category problems (Newbrander 2006). They have not been involved to a large extent in humanitarian crisis relief but have focused more on vertical interventions for specific diseases. Their resources can be helpful to fragile states for “plugging gaps,” such as helping with restarting a national tuberculosis program with a grant from the Global Fund. One potential disadvantage is that these programmes may be vertical and not integrated properly into the provision of basic health services that the fragile state is starting up. There may also be some questions about sustainability over the long term. GHPs are now also examining their role with regard to fragile states. GHPs can help countries, and especially fragile states, address major public health problems, but the challenge is to make sure GHPs contribute to the overall development of the health system.

There are now over 70 such partnerships in the health arena alone (Tayler 2005). Where donors are supporting the development of specific programmes, it would be sensible to establish systems that are potentially coherent and compatible with a broader range of functions, and that do not impede or distract attention from other high priority programmes. Global health partnerships, or some of their partners, need to develop a different approach to fragile states, with a more hands-on role, better monitoring and more strategic approaches to the fundamental constraints around effective implementation.

Since 2002, the Global Fund has invested nearly US\$ 5 billion in 41 fragile states, and most grants have been assessed as performing well. Nonetheless, statistically significant differences in performance exist between fragile states and other countries, which were further pronounced in states with humanitarian crises (Bornemisza, Bridge, Olszak-Olszewski, Sakvarelidze, & Lazarus 2010). As of May 2010, there were 489 active Global Fund grants, of which 198 (40%) were in fragile states. The overall share of approved grants allocated to fragile states had not changed significantly since the Global Fund was established in 2002. Both fragile states and other recipient countries averaged between four and five active grants per country. In fragile states, active grants were, on average, achieving 83% of their agreed targets for main program indicators—slightly below the average for other recipient countries, which were achieving 88% of their targets. This difference was statistically significant, and was slightly more pronounced when considering grants in fragile states with humanitarian crises in the last five years (which achieved 80% of their agreed targets).

By mid-2010, the Global Fund had disbursed 46% of its overall funding to these states, which appears to be proportionate to the reported disease burden. Fragile states represent 34% of Global Fund recipient countries, but accounted for 40% of all active grants. The worse performance in conflict-affected countries may be linked to the crises themselves, to political instability, to problems of local capacity, increased risk of corruption etc. The more difficult context may call for more flexible approaches by the Global Fund. However, in general, its operating principles fit well with the OECD DAC Principles for Good International Engagement in Fragile States and Situations (Bornemisza, Bridge, Olszak-Olszewski, Sakvarelidze, & Lazarus 2010).

Aid volumes & allocation

Aid flows are estimated to be seven times less predictable than domestically generated revenue, and twice as volatile again in fragile states as in other low income countries. A DAC study has shown that volatility is sometimes related to conflict resumption, but largely to changing donor policies (Tayler 2005).

There is a risk that large aid flows might undermine macroeconomic stability¹⁵ and have a negative impact on exchange rates. The law of diminishing returns in aid effectiveness does still apply. However, according to most analyses, most fragile states are under-aided. Collier's analysis suggests that in "normal" low income countries under stress, aid up to 20% of GDP can be effectively used – far in excess of existing flows to most fragile countries (Tayler 2005).

Official Development Assistance (ODA) disbursement for reproductive health activities to 18 conflict-affected countries was analysed for 2003, 2004, 2005, and 2006 (Patel et al. 2009). An average of US\$20.8 billion in total ODA was disbursed annually to the 18 conflict-affected countries between 2003 and 2006, of which US\$509.3 million (2.4%) was allocated to reproductive health. This represented an annual average of US\$1.30 disbursed per capita in the 18 sampled countries for reproductive health activities. Non-conflict affected least-developed countries received 53.3% more ODA for reproductive health activities than conflict-affected least developed countries, despite the latter generally having greater reproductive health needs. ODA disbursed for HIV/AIDS prevention and treatment increased by 119.4% from 2003 to 2006. The ODA disbursed for other direct reproductive health activities declined by 35.9% over the same period. The findings also demonstrated funding inequities between conflict-affected countries, as countries such as Democratic Republic of Congo and Somalia with the worst health and development indicators did not receive aid that was proportionate to need. Overall aid to conflict-affected countries increased over the period and conflict-affected countries also received more per capita total ODA than non conflict-affected countries, although still not necessarily proportionate to need.

What influences donors' allocations to fragile states? Politically, there may be concern about a government's lack of focus on poverty reduction, governance or human rights, as well as a lack of accountability to citizens and/or endemic corruption (Tayler 2005). On the economic side, there are often concerns about weak financial management systems, the fungibility of aid, macroeconomic impact, and diminishing returns in aid effectiveness. Practically, it is much more difficult to spend money well in fragile states: lack of infrastructure, systems and human capacity are all major problems, which in many instances are compounded by insecurity and the duplication of dysfunctional systems. The problem is not one sided, however. Donor short-termism, rigid adherence to over-designed projects, and fragmented, unharmonised inputs can all be problems. Donors also often experience difficulty in recruiting experienced staff to work in fragile states (Tayler 2005).

Other sources of revenue and risk pooling

Financing strategies

Few countries – in general, and perhaps especially post-conflict countries – have a clear health financing strategy, to indicate the volume and trajectory of different funding sources and their implications for sector development. This was noted in the study relating to SWAp-readiness (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011).

To transition from relief to development, countries must move through a number of stages—relief, rehabilitation, reconstruction, and development—across several critical areas (service delivery, setting the agenda, and financing). As countries emerge from conflict during the early post-conflict period, NGOs generally provide most of the services and are financed by international assistance (Newbrander, Waldman, & Shepherd-Banigan 2011). Over time, as government gains the capacity to set priorities, ensure the delivery of services, and manage funds, the public sector takes over these responsibilities. This envisages a normative trajectory in which the shift from conflict to post-conflict is associated with a shift away from the international community as chief financing source to a wider base (Newbrander 2006). Others present a different picture: the two main trends in health financing post-conflict are an increasing reliance on informal payments and on donor funding (De Vries & Klazinga 2006).

User fees

Studies point to a need to reduce ex ante payment barriers and to ensure equitable physical access as key to equity (in post-conflict as in other contexts) (Abu-Zaineh et al. 2011; Poletti 2003). In and post-conflict, financial access deteriorates as a result of a combination of the impact of conflict on livelihoods and incomes, the collapse of the financial protection function of the health system, and an increasing reliance on user fees (in response to inadequate government health budgets and insufficient donor financial commitments, both in terms of amounts as well as in terms of long term commitments). The three key drivers of catastrophic payment which have been identified for developing countries— the necessity of payment to access health services, low capacity to pay, and the lack of prepayment or health insurance — are all present in conflict-affected fragile states. Non-governmental organisation assessments suggest that the capacity of user-fees to raise significant amounts of money in complex emergencies is very limited, and the higher the cost of accessing care in complex emergencies, the lower the utilisation (Ranson, Poletti, Bornemisza, & Sondorp 2007).

This has led to a consensus in relation to crisis periods and essential health care: ‘Humanitarian aid must not introduce or support a financing mechanism for which sufficient evidence exists that indicates that it has negative effects on access to primary health care for the most vulnerable and excluded groups. Universal access to primary health care is a fundamental element of any humanitarian health response for populations affected by crises. During humanitarian crises, primary health care services are designed to cover the priority health needs of the affected population, including referral to secondary healthcare facilities and the treatment of more complex cases’ (Global Health Cluster & Inter-Agency Standing Committee 2010).

However, in a longer term post-conflict context, such as Cambodia, where low salaries have generated high informal fee payments, a shift to official fees which are reinvested in quality improvements can generate benefits for patients and services, if it reduces the overall effective fee (Akashi 2004). Community perceptions of quality of care, appropriate care-seeking and need are also important (Matsuoka et al. 2010). Others also counsel caution about removal of fees where this may be one of the few functioning systems at local level for funding services (Tayler 2005), and where, for example, the banking system is often rudimentary or nonexistent, so it can be difficult to disburse money (for salaries and recurrent costs) to local health clinics in a timely manner (Alliance for Health Policy and Systems Research 2008).

Controversy over this element of financing policies continues. For example, prior to the Comprehensive Peace Agreement in South Sudan, an SPLM policy document had established a decentralised user-fees system, aiming to cover 30 per cent of recurrent costs. Experience with the system was mixed, with total revenues amounting to only one per cent of recurrent expenditure, and a substantial drop seen in utilisation when it was introduced, according to one small-scale study.

A prescription to adopt user fees appeared in the first draft of the new health policy, but was criticised by the World Health Organisation on equity grounds and by the World Bank for contradicting the Constitution's commitment to free primary health care. Subsequent drafts of the health policy made no reference to user fees and did not prescribe their use, but their role continues to be debated (Cometto, Fritsche, & Sondorp 2010).

Waivers and health equity funds (HEF)

Short of fee removal, waivers and equity funds offer ways of ameliorating the negative impact of user fees on specific groups. One study from Afghanistan suggests that community-based targeting of waivers is feasible in a fragile setting, and indeed may contribute to rebuilding trust in institutions at the community level (Steinhardt & Peters 2010).

All evidence on health equity funds is drawn from Cambodia. Thmar Pouck Hospital was linked to a 'Health Equity Fund', managed by the local non-governmental organization – the Cambodian Association for Assistance to Families and Widows. This organization identified the poorest patients and paid their hospital fees, financed by MSF. Since the introduction of these initiatives in late 2000, the number of hospitalizations in Thmar Pouck hospital more than doubled. A similar Health Equity Fund in Sotnikum, Cambodia, was less successful (Hardeman et al. 2004): while the fund was found to effectively improve financial access of the poor, the poor continued to face many constraints to timely access. Particularly problematic were demand side barriers created by a lack of awareness of the fund by the majority of the people who were eligible. Even those who benefited from the fund learned about it only when they presented to the hospital. Both of these observations suggest that the fund did little to reduce uncertainty about financial access.

In both of these Cambodian cases, the authors emphasize that the equity fund is only one complement to a relatively well-functioning health service, in which health staff are present, drugs available, and informal charges absent. This observation suggests that health equity funds would be of limited use in most immediate post-conflict settings until a reasonable level of service has been restored (Ranson, Poletti, Bornemisza, & Sondorp 2007).

There has been success in terms of scaling up of HEFs. They were included in key MOH and government strategic documents in 2002 (the Health Sector Strategic Plan and in the Poverty Reduction Strategy), when the first HEF policies were developed (Por et al. 2010). Early lessons on implementation were generated by the pilots, with strong involvement of international actors and NGOs. Knowledge dissemination was helped by sectoral structures, including the sector-wide management strategy launched in 2000. The pro-poor feature of policy and the fact that it mobilised additional resources for public facilities counted in its favour. The Ministry of Health's Forum on HEF reached a consensus on the positive impact of HEFs in terms of access to public health services for the poor, but concluded that the knowledge on mitigating the impoverishing effect of illness on the poor was ambiguous. Furthermore, key policy aspects of HEF remained partly unresolved, like the beneficiary identification methods, organisation and management model, benefit package, reliable funding source, and monitoring and evaluation. Key informants from non-governmental organisations and some donor agencies preferred HEFs to be managed by a third party independent from the Ministry of Health, whereas government key informants argued that it would be more efficient and sustainable if HEFs were managed and monitored within the existing MoH structures. In late 2006, the MoH and Ministry of Economy and Finance jointly issued a directive to allocate part of the state budget to subsidise health care costs for the poor through reimbursement of the cost of user fees for exempted poor patients. However, the effectiveness of this government-led model needs further assessment (Por, Bigdeli, Meessen, & Van Damme 2010).

Despite the widespread HEFs in Cambodia, considerable financial barriers remain (Grundy et al. 2009). On the demand side, very low utilization rates for facilities are often related to financial barriers to users. About one third of the population is too poor to pay for health care in the public or private sectors. Total annual health expenditures in Cambodia are US\$37 per capita, of which \$25 (68%) is private, out-of-pocket expenditure. With 35% of the population living under the national poverty line of \$0.46–0.63 per day, health expenditures can tip those living above this line into poverty.

Community health financing

The evidence on the potential role of CHF in post-conflict settings is extremely limited, although studies from Rwanda suggest that voluntary, community-based health insurance may ameliorate the inequitable effects of user fees (Schneider & Hanson 2006).

Demand-side financing

There is no literature identified on demand-side financing which focuses specifically on the challenges or opportunities offered by a post-conflict or fragile setting. A recent review of demand side financing for sexual and reproductive health in low and middle-income countries found most schemes operating in more stable contexts (Witter 2011). This may in part relate to the managerial complexity of some of the schemes. The paper also points out that adequate services must be in place if demand-side financing is to be effective in raising utilization and improving outcomes. In Nepal, for example, the roll-out of the Safe Delivery Incentive Programme was accompanied by considerable other investments in establishing and equipping birthing centres and improving training of staff, amongst other activities. An underutilized health system, functioning reasonably well, with competition between different suppliers, is the ideal context for introducing a demand-side financing scheme (Witter 2011).

The assumption that improving the affordability of the service alone will raise demand does not always hold. In the case of Cambodia, the low utilization of delivery vouchers (which covered the full range of costs, including transport) raised the issue of cultural perceptions and other (non-price) barriers. Interviews with non-users revealed that concerns about finding transport to facilities, about poor staff attitudes in facilities and about taking care of their household were responsible for women not using their vouchers (Por et al. 2008).

Resource allocation, purchasing and service provision

Resource allocation

Resource allocation is not a common topic in literature on post-conflict or fragile states, perhaps because it implies an organised approach to distributing resources which is lacking in many weaker health systems. 'The most common pattern recognizable in weak (not necessarily "disrupted") health sectors is the proliferation of priorities, progressively endorsed to appease and co-opt old and new actors and to tap additional resources. The existence of too many priorities implies no true prioritization, which may result in the spreading of scarce resources and capacity across multiple activities, and in the inadequate implementation of all of them. Alternatively, decision-makers may decide to pay lip service to policy documents and make allocations according to their true, not stated, priorities. A clear consistent direction is rarely recognizable as the result of this fragmented, escapist decision-making' (Pavignani & Colombo 2009).

However, there are those who argue that financing allocation formulas that recognize the disproportionate need in areas experiencing greater violence and with more vulnerable populations should indeed be a priority for post-conflict areas (Kruk, Freedman, Anglin, & Waldman 2010).

Working with non-state actors

By contrast, there is a substantial literature on working with non-state actors in post-conflict and fragile states. In dealing with these contexts, donors have frequently adopted a strategy that substitutes an international agency or NGO for the state. This is particularly the case in humanitarian emergencies, where there is a short-term urgent need to provide access to certain services. Internationally recognised bodies then take on some, or all, of the policy-making tasks, including identifying the level and quality of services to be delivered. Contracts for services to non-state actors may produce short-term benefits in terms of enhanced service delivery, but there are problems in terms of building sustainable service-delivery systems for the long term. This ‘two-track problem’ poses a real dilemma between mitigating immediate humanitarian needs and delaying the establishment of durable, local service delivery (Commins, 2010). However, the problem may lie not so much with non-state actors operating separately from state agencies, but rather in the lack of any overall policy or coordination framework, both among donors themselves, and among donors, governments, and non-state actors.

A major source of finance for the health sector is likely to be out of pocket, and much of the delivery will be by the private sector. Talyer (2005) argues that donors must be prepared to invest in developing new roles and skills to reflect the new role of the state as it moves from monopoly provider of services to steward of the whole sector. It is also important to be realistic about the capacity and probity of the non-governmental sector. While it may seem appealing to bypass government systems and work with NGOs and the for-profit private sector, there is no guarantee that these groups will be any more efficient, accountable, or less corrupt.

A legacy of state-avoidance strategies, particularly after a prolonged conflict, can embed a parallel structure in the service-delivery landscape, leaving the state relatively weak and under-resourced in favour of NGOs. An internal review of DFID’s portfolio in fragile states noted that there are ‘unintended consequences’ of non-state services, including unsustainable operational standards and facilities; lack of upward and downward accountability of service providers; the failure of humanitarian agencies to develop sustainable local capacity; and the tendency for service providers to attract hostility from the state, because of their unintended political role (DFID 2009). In stabilising states the OECD advocates arrangements where government may not be the direct provider of services but nevertheless assumes responsibility for making policy, contracting other providers, and regulating and monitoring services. However, many governments struggle with these roles. There appear to be few publicly available evaluations of donor programmes which have aimed to strengthen state capacity to perform the indirect roles (Batley & McLoughlin 2010). These include the following:

- engaging non-state providers (NSPs) in policy dialogue, and formulating policies that provide the framework for service providers;
- regulating by setting minimum standards and enforcing them, licensing, accrediting and facilitating providers, and safeguarding consumers;
- contracting out government-financed services to NSPs or contracting in the support of NSPs to government services;
- entering into mutual agreements for jointly financed collaboration between the state and NSPs.

The major constraints on the performance of the roles of creating the policy environment and engaging in policy dialogue are at the level of i) incentives, or willingness on the part of both NSP and government to engage, and ii) lack of information and technical and administrative capacity to engage effectively (Batley & McLoughlin 2010).

Command and control regulation may be used against the non-state sector where there is a direct government service to protect and there is competition for resources and customers. Double standards, whereby the government asks private operators to abide by requirements far beyond those attained in public facilities, are common in weak and disrupted health systems, for example in Afghanistan, Northern Uganda and Angola (Pavignani and Colombo, 2009).

The development of more informal and mutual arrangements is an area which can evolve over time, as states exit from conflict. An example of this is the evolution of government relations with mission health facilities in Zimbabwe, Uganda, Tanzania, Uganda and Papua New Guinea. Historically these operated on the basis of missionary funding but, as this source declined, they were either taken over or part-funded by governments. Informal, mutual and local-level engagements provide opportunities for learning and the development of trust between state and non-state actors, but, on the other hand, present problems of 'scaling-up'. Donors have invested less in supporting these than in higher risk, higher capacity-requiring activities such as whole-scale contracting and formal regulation (Batley & McLoughlin 2010).

NGOs play a relatively more important role in service delivery than in more stable environments because they have often formed the "backbone" of humanitarian services during conflict and have continued services post-conflict in each country by an extension of relief aid (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). This has been due to protracted periods of transition, primarily as a result of donor delays in shifting aid modalities from humanitarian to development aid. The lack of a well-established transition mechanism often gives this kind of humanitarian aid a structural character, as exemplified in eastern DRC over the last twenty years.

Contracting

The discussion of contracting is closely linked to that of the role of non-state actors. One of the first contracting experiments in a post-conflict setting was carried out in Cambodia between 1999 and 2003. Studies found that when contractors (who were mostly international NGOs) entered into contractual obligations to provide health services, they performed better than the government at reducing inequities (Bhushan, Keller, & Schwartz 2002; Bloom et al. 2006; Loevinsohn & Harding 2005). Although the study methodology has since been criticised (for not allowing for other differences between intervention and control areas, for example), the results were influential in other countries.

Some, but not all contracts, have built-in rewards relating to performance. In Haiti, the United States Agency for International Development (USAID) had since 1995 supported NGOs providing primary health care in rural areas, but by 1997 they realised that there was a very wide variation in coverage and quality. A decision was made to offer NGOs 95 per cent of their original contract payment, in exchange for performance bonuses worth 10 per cent of the contract amount if they achieved agreed-on targets. By 2005, 100 per cent of children were fully immunized, compared to 34 per cent in 2000. In addition, in the same five year period, 60% of women received at least three prenatal care visits, compared to 29% in 2000 (Loevinsohn 2008).

Since then, contracting has been selected as a primary mechanism to support the health sector by donors in Afghanistan, the DRC, Liberia and southern Sudan (Newbrander, Waldman, & Shepherd-Banigan 2011). A lack of national resources has resulted in continued reliance on international

donors to fund NGOs to provide health care. However, in several countries, donors and governments are working together in innovative ways to build the capacity of ministries of health to manage and administer funds to NGOs. In Liberia, for instance, the Ministry of Health and Social Welfare has instituted an Office of Financial Management within the department to administer a pooled fund. The Ministry will use some of the resources to pilot a contracting scheme to fund provincial health teams to deliver basic services.

In the DRC, the World Bank's Health Sector Rehabilitation Support Project (PARSS) utilises performance-based contracts between the MoH and implementing partner agencies to meet national health performance targets (Waldman 2006). In southern Sudan, the Multi-Donor Trust Fund, which was established in 2006, similarly contracts out services to international NGOs.

In Afghanistan, starting in 2002, the Ministry of Public Health contracted 27 non-government organisations covering 31 of the 34 provinces of Afghanistan to implement the Basic Package of Health Services (BPHS), retaining responsibility for service delivery in the remaining 3 provinces (Palmer et al. 2006). The MoPH retained overall stewardship of the health sector. The use of contracting by three major donors has increased access to basic health services from 5% in 2002 to an estimated 77% in 2006 (Newbrander 2006). However, despite gains in access to services, a survey in 2005 found continued inequalities in terms of use of services, ease of access to facilities and cost of care, with greater barriers faced by poorer and disabled households (Trani et al. 2010). The need for more bottom-up mechanisms for involving users in developing the health care system are highlighted by these authors.

Moreover, not all view contracting as an easy option for governments in fragile states: in fragile contexts, where governments cannot guarantee political and economic stability or a legal system that would ensure contractual rights, formal contracting can hardly be effective (Batley 2006). In Cambodia, for example, the effectiveness of public-private partnerships has been hampered by the widespread lack of transparency, the government's failure to negotiate contracts openly and the tendency of government officials to bypass laws and administrative processes in awarding contracts. There can also be profound cultural and institutional constraints that manifest themselves as social and political resistance to the involvement of non-state providers, and lack of political capacity to face down official interests (Batley & McLoughlin 2010).

It can also not be assumed that the necessary will or capacity to enter into contractual agreements exists within the non-state sector, any more than in government. There is a risk that tight performance-based contracts, in particular, may rule out the local and informal providers that are often most important to poor people. In Sudan, for example, the scale of the contracts being offered – to deliver health services in entire provinces – meant that some NGOs were unwilling, or unable, to take them on. The Ministry of Health has had to revise the terms to make them more appealing to NGOs (Carlson 2007). NGOs may also be unwilling to enter into contracts with government because of weak financial incentives, lack of trust in government, and lack of confidence in its ability and commitment to pay (McLoughlin 2008). Thus there is a tendency to depend heavily on donors.

Partnerships are however only likely to be effective if governments maintain an active role in the management of the agreements, rather than being left as a third party as international donors collaborate separately with NGOs. Whereas in Afghanistan, government has retained such a role in the donor-funded Grants and Contract Management Unit, in the Democratic Republic of Congo government has been more or less excluded from the process, amounting to a 'state avoidance' strategy (Waldman, 2006). Direct funding of NGOs by donors may undermine government capacity-building, even where the plan is eventually to transfer the service-delivery function to the state. In Afghanistan, 'local health offices have little in the way of capacity, and resources flow directly to

NGOs from Kabul. NGO salaries are higher and more reliable than government salaries, facilities where staff are only receiving government salaries were found to be largely non-functional ... It is not surprising that local health departments find it difficult to exert their own authority in this situation' (Zivetz 2006).

Central authority is limited and in places highly compromised. Despite the existence of a basic package of health services, decentralisation to non-state providers means that fragmentation is virtually inevitable. There is no standardised practice in areas such as on user fees, drug procurement systems, and deployment of community health workers (Palmer, Strong, Wali, & Sondorp 2006). However, in certain post-conflict settings, where dependency on non-state providers is entrenched and government capacity feeble, contracting out service delivery can represent the only feasible policy option (Cometto, Fritsche, & Sondorp 2010).

Basic packages of health services

Another closely linked topic to non-state providers and contracting is the use of basic packages of health services (BPHS). These are seen as a primary strategy for rapid extension of services in post-crisis situations, and in order to address geographical inequities in service delivery (Ranson, Poletti, Bornemisza, & Sondorp 2007). The PBHS in Afghanistan, for example, has become a model for the reconstruction of health systems in post-conflict countries (Newbrander, Waldman, & Shepherd-Banigan 2011).

The country's government, with assistance from donors, the UN and NGOs, decides the content of the package based upon the country's health needs and the cost-effectiveness of interventions in relation to the resources available for the package. The service delivery levels generally include health posts, health centres and district hospitals. The content of the package is primarily based upon internationally recognised cost-effective interventions and endorsed by the country's government. These interventions commonly include maternal and newborn health, reproductive health, child health and immunisation, communicable diseases and nutrition. Additional services can also be included, depending on the country's particular health needs. The funding is either coordinated by allocating donors to provinces, as in Afghanistan, or is centrally pooled, as in Southern Sudan (Roberts et al. 2008). The country's government is expected to contribute financially to the BPHS over the longer term.

The BPHS contracting approach is viewed by some as an intermediate measure to last for a few years until the country's government can resume providing services directly, while others argue that this could become a more permanent feature of organising health service delivery (Roberts, Guy, Sondorp, & Lee-Jones 2008). Concerns are expressed about the non-included services (e.g. services addressing sexual and gender-based violence), the degree of competition for contracts, the longer term effects on systems capacity and the impact on more specialist providers, which may have implications for the quality of services provided. The authors also express concern about the need to fund other activities such as advocacy for sexual and reproductive services, which are often contested and subject to local stigma. If the BPHS is the main funding vehicle, NGOs and other organisations may not feel able to criticise policy, if that might compromise their funding (Roberts, Guy, Sondorp, & Lee-Jones 2008).

In Afghanistan, Southern Sudan and the DRC, where the governments in power retain overall responsibility of stewardship, BPHSs may have helped to establish clear policies and provide a sense of direction for development partners to follow and align with (Eldon, Waddington, & Hadi 2008). In these countries, provision of a BPHS may have helped to demonstrate state capacity, contributing to enhanced legitimacy. Among the results that have been documented in Afghanistan are a substantial reduction in child mortality, increased immunisation coverage, and higher coverage in reproductive

health services. This has been attributed to a clear focus in the Basic Package on delivery by NSPs and oversight by the Ministry. While the Basic Package has had success in areas where security has allowed for NSP operations, questions remain over whether it can contribute to state building and state legitimacy given the larger political factors and ongoing level of violence (Commins 2010).

An evaluation of the Basic Services Fund in Southern Sudan found that, whilst most NGO contracts included provision for training government staff, establishing community structures to oversee them, phasing out NGO incentives and handing over staff to the government payroll, there were almost no instances where this had actually occurred. Ministries were simply in no position to take over staff. Contact between NGOs and government was at the level of information-sharing and consultation rather than co-planning, with the result that there was little sense of government ownership (Batley & McLoughlin 2010).

Performance-based funding (PBF)

PBF is an allied topic – it can include contracting as one of its mechanisms, particularly when contracts contain financial incentives to deliver specific outputs or targets. Many of the non-OECD countries which have been experimenting with PBF in the health sector in the past decade have been post-conflict countries (such as Rwanda, Burundi and the DRC). Of these, Rwanda is the best documented example (Basinga et al. 2011). Some commentators have suggested that PBF has worked better in post-conflict settings (Toonen et al. 2009). If this is the case, a number of reasons have been hypothesized – that there is less inertia in the system; that providers have lost some of their intrinsic motivation and are therefore more amenable to financial incentives; that control mechanisms are weak and therefore need to be replaced by other levers; that central funding may have broken down in any case, leaving providers open to market failures etc (Witter 2012).

The emergence of viable institutional arrangements for PBF in fragile state contexts may also be due to a vacuum in the existing governance and policy environment which allows for the building of ‘new’ institutions appropriate to the need (Toonen, Canavan, Vergeer, & Elovainio 2009). The theory is that in non-conflict situations, systems are much more developed and fixed while in the recovery stage post-conflict there is an opportunity to innovate and try to develop new systems.

On the other hand, if the context is too hostile, then it is unreasonable to expect implementers to achieve significant increases in outputs. This was a point made by implementers in Southern Sudan, who faced penalties for not meeting targets, which they felt were unreasonable given the many challenges of the nascent health system (Morgan 2010). Problems listed included lack of access by the population, shortages of staff, poor staff pay, and drugs supply problems. These were exacerbated by process issues, such as lack of consultation on targets, targets being measured too frequently, and issues of credibility of baseline data (Morgan 2010).

In terms of the effectiveness of PBF as a funding mechanism, a recent systematic review concluded that ‘the current evidence base is too weak to draw general conclusions; more robust and also comprehensive studies are needed. Performance-based funding is not a uniform intervention, but rather a range of approaches. Its effects depend on the interaction of several variables, including the design of the intervention (e.g. who receives payments, the magnitude of the incentives, the targets and how they are measured), the amount of additional funding, other ancillary components such as technical support, and contextual factors, including the organisational context in which it is implemented’ (Witter et al. 2012).

It also noted that ‘almost all dimensions of potential impact remain under-studied, including intended and unintended impact on health outcomes, equity, organisational change, user payments and satisfaction, resource use and staff satisfaction’ (Witter, Fretheim, Kessy, & Lindahl 2012).

In countries such as Afghanistan, gains in utilisation have been attributed to PBF. However, only World Bank contracts (covering eight provinces), offer performance incentives (NGOs can earn bonuses of up to 10% a year for specific amounts of improvement in specified performance indicators). There is no evidence that overall improvements are less in areas with different contracting arrangements (USAID and EC-supported provinces) (Benderly 2010).

Regulation

There is little written on how regulatory tools might operate differently or need to be tailored to post-conflict/fragile settings, though in general, forms of regulation where the rules are slimmed down, focused more on the quality of outputs and based more on incentives, and which focus on substitutes for state regulation, such as external and self-accreditation, franchised service provision and community monitoring, place fewer imposed demands on the actors and are therefore thought to be more suited to improving services in these settings (Batley & McLoughlin 2010).

Financial management

Public financial management (PFM) is another area which has received relatively little attention, though it is of course central to rebuilding health financing systems. Public Expenditure Financial Accountability (PEFA) assessments provide opportunities to systematically evaluate and score the quality of PFM systems at a nationwide level over time. Scores indicated that Sierra Leone and Timor Leste compared relatively well with other low income countries (Rothman, Canavan, Cassimon, Coolen, & Verbeke 2011). PFM capacity in DRC however was judged to be extremely low. Donors were not extensively using programme-based approaches and more aligned aid modalities.

This is a problem noted in a number of fragile states. In Cambodia, relatively low allocations of government budgets reach health care facilities, mostly due to inadequate financial management (Grundy, Khut, Oum, Annear, & Ky 2009). Despite a 264% increase in government health expenditure between 1998 and 2004, delayed and incomplete financing of the operational costs of primary care services continue to limit the quality and coverage of immunization and other health programs. Adding to this are capacity constraints for decentralized health planning and financial management, including the limited development of banking systems at district level and below. As a result, programmes, international projects and national programmes are often managed and funded separately from distinct project administrations, reporting systems and financial flows (Grundy, Khut, Oum, Annear, & Ky 2009).

Discussion

This literature review was not exhaustive. It focussed on publications in the period 2000-2011 and on English-language publications. It sought publications that focussed on health financing, with a fragile states or post-conflict lens. There are many studies about health financing in post-conflict states but which are excluded because they do not explicitly consider the context implications. In addition, drawing boundaries during study selection inevitably involves an element of judgement about which topic contains insights relevant for health financing.

Despite these caveats, some interesting insights were generated. First, it is clear that this area grew in interest for funders and researchers over the 2000s – an interest which may well be maintained in

light of the ongoing concern with the security threat posed by fragile and post-conflict (or possibly inter-conflict) states.

The majority of studies focus on fragile states, but as many of these are post-conflict, the review has focussed on findings from all studies, whichever context definition they use. Definitions are in any case very varied and all involve some degree of judgement. Deficits in governance, unwillingness to deliver core services, lack of resilience, or lack of effectiveness, for example, are terms which could be applied to some degree to many states, stable or fragile, post-conflict or not. Moreover, the classifications tend to group together states facing very different challenges, as writers acknowledge.

In terms of findings, the health system features which fragile states are said to possess are shared by many low-income countries, though generally to a lesser degree. The group as a whole present higher needs than non-fragile/conflict-unaffected countries, and there is both a humanitarian and strategic interest in addressing these, although the evidence for the effectiveness of the growing assistance is less clear. There is an interest in how health sector investments contribute to state building, but the evidence to date is inconclusive. However, health financing arrangements can convey important messages about political priorities and values.

The focus of the studies is overwhelmingly on the role of donors –in the form of identifying good practices for donors in providing support post-conflict in general, discussing the lessons of experiences engaging in policy formulating post-conflict, examining aid coordination, discussing the implications of different aid instruments, tracking changing aid flows, evaluating the impact of global health initiatives, and debating the role of donors in working with non-state actors, or the position which they should take on issues such as user fees. This focus is perhaps understandable given the influence and funding which donors are thought to bring in the emergency and post-conflict periods. However, donor dependency of various forms is not confined to these states and it would seem important to broaden the focus.

Within the literature on the role of aid, there is a consensus amongst commentators that developing government capacity and stewardship is important, particularly as the emergency period recedes. Equally, there is considerable evidence that this is often neglected in practice. Significant policy reforms can sometimes be introduced through the influence of external actors in the post-crisis period, but embedding these is harder and few case studies follow the subsequent developments.

The emphasis is in general on the immediate post-conflict period, and few studies take a longer perspective to examine policy and financing developments over time, and how the post-conflict decisions influence or not later sector development. Research methods are mixed and reflect the difficulty of collecting original data in many of these settings.

Funding gaps can occur as countries transit from humanitarian to development assistance, but these are not inevitable, if there is some flexibility in aid instruments. Many of the lessons learned about aid effectiveness are generic to all settings (longer term commitments and flexibility, for example, are positive, wherever they occur, though again, the need for them may be greater in fragile settings). Tensions between acting swiftly and opportunistically and 'state avoidance' are highlighted. Gaining a good understanding of a complex and dynamic context is a major challenge for donors. A high degree of aid fragmentation and volatility continues to pose problems for fragile countries in particular.

In relation to health financing more generally, there is an assumption by some that countries will shift from being highly donor-dependent in the post-conflict period to broadening their domestic revenue base, though this seems to be normative, rather than based on any empirical evidence.

The limited literature on user fees post-conflict mirrors the wider debate – torn between principled opposition (based on the fact that populations are particularly unable to bear the cost of care post-conflict) and pragmatic acceptance (based on the fact that removal of fees is not easy and that some alternatives are worse). Alternative approaches to wholesale removal, such as health equity funds, have only been tried in very specific contexts, and their longer term effectiveness and wider use is not yet established. There is very limited discussion of other health financing options in fragile contexts, such as community health financing and the utility of demand side financing approaches. Further, very little has been published on equity and access in post-conflict settings, including household payments, affordability and use of services, coping strategies etc. It is likely that there is a larger grey literature amongst operational agencies, which may not be publically available. Topics such as resource allocation are also neglected.

By contrast, there is a large literature on contracting, working with non-state actors, and use of basic packages of health care. This is portrayed as a relatively quick solution to the need to build up services and coverage quickly post-conflict. There is a paradox here in that these are generally understood to require a degree of public administrative competence to operate effectively, and yet are being proposed particularly in the context of states with lower capacity. The paradox is solved in many contexts by donors and INGOs taking management responsibility to a large degree – a situation whose longer term effects are yet to be understood in countries like Afghanistan. The role of non-governmental organisations, which can continue to play an important role in the post-conflict period, is better documented, though again, the longer term effects of this are not. More informal relationships, such as between public administrations and the mission sector, though widespread, are much less well studied.

In relation to performance-based funding, an interesting debate is emerging over whether it is particularly suited to fragile or post-conflict settings. Certainly, some of its most widespread and best documented uses in low and middle income settings to date have been in post-conflict central Africa. There may be other factors at play here, but some have speculated that the search for new approaches and lack of entrenched interest groups, as well perhaps as the limited formal supervisory arrangements for facilities and staff, can make PBF both easier to introduce and perhaps more successful in these contexts. This is as yet merely a hypothesis however. PBF itself is very much an umbrella concept, including a wide variety of designs.

Other topics which have not received much attention in post-conflict states, despite their evident importance, include regulation (for example, what tools are best suited to such contexts?) and public financial management (for example, how to strengthen the management of public resources at all levels in weaker health systems?).

These findings accord with the few other reviews of the area which have been conducted. Research on health systems in conflict-affected fragile states tends to be piecemeal and small scale, and there is a dearth of policy-relevant insights and analyses, according to one review (Alliance for Health Policy and Systems Research 2008). It found that within the humanitarian field, despite the substantial literature on aid, refugees and internally displaced people, as well as on disease-specific issues, little attention has been paid to health system and policy issues. What little literature there is tends to be descriptive case studies. While these can be useful for sharing policy-relevant lessons, most do not seek to address a specific research question, and they are generally not conducted using rigorous research methods.

The authors argue that there is a need for research into approaches to increasing coverage of marginalized and vulnerable populations; strengthening the resilience of communities and local

health services; developing new models of service delivery and performance-based financing; and working effectively with non-state providers who often deliver the majority of services in fragile states. In addition, the aid environment and policy processes should themselves be examined, given their influence on programming and, ultimately, health outcomes (Alliance for Health Policy and Systems Research 2008). They recognise that as health systems in fragile states are often forced to innovate, they can generate useful lessons for stable settings too. These recommendations may be a bit dated; our literature review has found three of these five areas to be the focus of existing literature.

Conclusion

There is a growing but still very limited literature on health financing in post-conflict countries. Most of the insights from existing literature relate to the role of donors. A longitudinal approach, which examines how decisions taken in the immediate post-conflict period may or may not influence longer term developments, would be particularly welcome. In addition, this review draws attention to the need for more work on questions of access to care and equity, on the mix and sequencing of financing mechanisms, on resource allocation, regulation and public financial management, on payment systems and incentives at facility and health worker levels, and on the overall health financing strategy and its possible contribution to wider state-building. Topics which have received attention, such as contracting and non-state actors, could benefit from more rigorous analysis with a longer time perspective.

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Table 5 Summary of main studies consulted

Title	Author	Publication	Year	Organisation/Institution	Definition for post-conflict/fragile	Research Methods	Countries/Regions	Major Themes	Main findings	Recommendations for further
Planning for health sector reform in post-conflict situations: Kosovo 1999 /2000	Dean A. Shuey, Fatime Arenliu Qosa, Erik J. Schouten, Anthony B. Zwi	Health Policy	2003	World Health Organization (Laos, Kosovo, Kenya); School of Public Health and Community Medicine, University of New South Wales, Sydney	Post-conflict; not defined	Not stated; description of process of health system assessment and policy development after 1999	Kosovo	Developing health policy and reforms post-conflict (especially in situations of disputed state mandates)	Kosovo is unique in being a post-conflict situation, in a former socialist country, with an unclear political future, under temporary UN administration. The World Health Organization (WHO) led a process of developing a health policy framework for the emergency period that included elements of health sector reform, a somewhat controversial initiative. Reform elements of the policy were consistent with normative health policies in much of eastern and central Europe. There was tension between the need to have a policy in place rapidly and the desire to be participatory. Although there was some tension between relief and development agendas, the policy process did direct significant resources and effort in directions that contributed to longer-term reform and development. A policy framework does not ensure compliance with policy unless issues of authority, mandate, and leadership are clear. A rapidly developed health policy framework at the onset of an emergency is desirable. Policy developers should be experienced, seen as being neutral and be relatively independent of any specific donor or interest group. WHO is well situated to play this role if it meets certain conditions.	None
User fees at a public hospital in Cambodia: effects on hospital performance and provider attitudes	Hidechika Akashia, Takako Yamada, Eng Huot, KoumKanal Takao Sugimoto	Social Science & Medicine	2004	International Medical Center of Japan; Ministry of Health, Cambodia; The National Maternal and Child Health Center of Cambodia; Kyushu Industrial Health Association, Japan	Not focussed on PC as such	Reviewed hospital data, and conducted patient and provider surveys, and provider focus group discussions	Cambodia (one hospital in Phnom Penh)	Formalising user fees in a public hospital - the effects on utilisation and provider and patient satisfaction	Before the introduction of user fees, the revenue from patients was taken directly by individual staff as their private income to compensate their low income. After the introduction of user fees, however, revenue was retained by the hospital, and used to improve the quality of hospital services. Consequently, the patient satisfaction rate for the user-fee system showed 92.7%, and the number of outpatients doubled. The average monthly number of delivery of babies increased significantly from 319 before introduction of the system to 585 in the third year after the user-fee introduction, and the bed occupancy rate also increased from 50.6% to 69.7% during the same period. As patient utilization increased, hospital revenue increased. The generated revenue was used to accelerate quality improvement further, to provide staff with additional fee incentives that compensated their low government salaries, and to expand hospital services. Thus, the revenue obtained user fees created a benign cycle for sustainability at NMCHC. Through this process, the user-fee revenue offered payment exemption to low-income users, supported the government financially through user-fee contributions, and reduced financial support from donors. Although the staff satisfaction rate remained at 41.2% due to low salary compensation in the third year of user-fee implementation, staff's work attitude shifted from salary-oriented to patient-oriented—with more attention to low income users.	None

Title	Author	Publication	Year	Organisation/Institution	Definition for post-conflict/fragile	Research Methods	Countries/Regions	Major Themes	Main findings	Recommendations for further research
Absorptive capacity of health systems in fragile states	Liz Tayler	Technical approach paper	2005	HLSP London	Uses DFID definition - states where the government cannot or will not deliver core functions to the majority of its people, including the poor	Not stated, but based on literature review	All fragile states	External engagement in fragile countries - strategies for improved donor investment	Whilst most donors have adopted a lower risk strategy of minimal engagement in fragile states, and have channelled most of their assistance through NGOs where they do engage, there have been successful exceptions. The unprecedented volumes of aid that are being allocated to health, and the escalation in the quality and quantity of analysis around investment in fragile states, mean that there are opportunities for major progress if these two forces can be brought together and translated into strategic action.	None
Contracting out health services in fragile states	Natasha Palmer, Lesley Strong, Abdul Wali, Egbert Sondorp	BMJ	2006	London School of Hygiene and Tropical Medicine	Fragile states - not defined	Commentary	Afghanistan	Contracting	Fragile states are increasingly contracting out delivery of health services to non-governmental organisations (NGOs). Afghanistan is the most recent and large scale example of contracting. Use of NGOs enables rapid expansion of health services. Other effects of this valuable new policy approach need to be monitored and evaluated.	The appropriate role of government, the capacity and motives of NGOs, and how to limit fragmentation need investigation.
Rehabilitating the health system after conflict in East Timor: a shift from NGO to government leadership	Alonso, A. and Brugha, R.	Health Policy and Planning	2006	LSHTM & Royal College of Surgeons, Ireland	Not defined	This study draws on participant observation by the lead author, while being an adviser on Policy and Management to the Ministry of Health of East Timor during the early years of health system reconstruction (2000-02), supported by a review and analysis of unpublished reports	East Timor	Post conflict role of external actors - shift from NGOs to government services	The external actors – UN agencies, donors and NGOs – and the nascent East Timorese leadership can all be credited for their contribution to the rapid transition from relief to development, and to the birth of an indigenous health system. The early definition of a phase-out strategy and close monitoring of its implementation were important for the success of the policy, as they allowed the government of East Timor to detect areas of potential risk after the withdrawal of NGOs. Favourable preconditions existed before the reconstruction, including widespread recognition of the legitimacy of the transitional administration, social cohesion within the state, small size of the country, and coordination facilitated by a high level of consensus among all actors. Such positive preconditions are often not present in other post-conflict situations.	None
Mental health reform in post-conflict areas: a policy analysis based on experiences in Bosnia Herzegovina and Kosovo	Albert K. De Vries, Niek S. Klazinga	European Journal of Public Health	2006	Ministry of Justice, the Hague; University of Amsterdam	Post-conflict; not defined	Review of grey literature and key informant interviews in 2002	Bosnia & Kosovo	The role of foreign influence in mental health reforms in post-conflict areas	Mental health reforms in the post-conflict areas of Bosnia Herzegovina and Kosovo have specific characteristics and dynamics, and are taking place within the context of huge foreign donor influence, overall health care reforms and reform of health care financing systems. Foreign influence accelerates mental health reform in post-conflict areas, but can also threaten its sustainability in various ways.	None

Title	Author	Publication	Year	Organisation/ Institution	Definition for post- conflict/fragile	Research Methods	Countries/ Regions	Major Themes	Main findings	Recommendations for further research
Innovations in Rwanda's health system: looking to the future	Dorothy E Logie, Michael Rowson, Felix Ndagije	Lancet	2008	QMU, Edinburgh; UCL London; Kigali, Rwanda	Not focussed on PC as such	Commentary/secondary data	Rwanda	Reviews three recent initiatives - aid coordination; CBHI; and payment for performance	If Rwanda succeeds in achieving improved health coverage through community insurance (with reliable exemptions for the poor) and in retaining health staff through improved pay and incentives, and if it attracts substantial additional aid that is reliable, coordinated with national policy, and sufficiently long term to support the whole of the health system, then these developments would indeed encourage other countries. In Rwanda's favour is a strong government that is interested in making health and equity of access a priority. The Government of Rwanda hopes to eventually shift from donor dependency to self funding but, despite substantial amounts of aid at the moment, the health services remain underfunded and understaffed.	None
A Basic Package of Health Services for Post-Conflict Countries: Implications for Sexual and Reproductive Health Services	Bayard Roberts, Samantha Guy, Egbert Sondorp, Louise Lee-Jones	Reproductive Health Matters	2008	Conflict and Health Programme, London School of Hygiene and Tropical Medicine; RAISE Initiative, Marie Stopes International, London	None given	Not stated, but is based on review of experiences from two countries	Afghanistan; South Sudan	Basic package of health services in post-conflict countries	The Basic Package of Health Services contracting approach could provide an important means for rapidly scaling up effective, efficient and equitable sexual and reproductive health services in countries emerging from conflict. However, there are a number of challenges relating to the availability and quality of services, and advocacy activities on sexual and reproductive health. If the potential opportunities provided by the Basic Package of Health Services contracting approach for the expanded provision of sexual and reproductive health in post-conflict settings are to be fully realised, government, donors, and NGOs will need to adopt a flexible and broadbased approach to help advance comprehensive reproductive health.	None
Analysing disrupted health sectors - a modular manual	Pavignani & Colombo	Report	2009	WHO	Uses the term 'health sectors in crisis'. This includes countries on the verge of an economic, political and/or military	Training manual	Various	Manual for how to analyse health systems in crisis. Includes chapter on health financing	N/a	N/a

Title	Author	Publication	Year	Organisation/Institution	Definition for post-conflict/fragile	Research Methods	Countries/Regions	Major Themes	Main findings	Recommendations for further research
Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia	Bruno Meessen, Wim Van Damme, Christine Kirunga Tashobya, Abdelmajid Tibouti	Lancet	2006	ITM, Antwerp; Universite Catholique de Louvain; MoH Uganda; UNICEF New York	Not focussed on PC as such	Commentary	Uganda, Cambodia	Comparing reduction of user fee burden via universal exemptions in Uganda and health equity funds in Cambodia	Develops some key questions to be asked of pro-poor reform, relating to barriers faced by the poor; targeting of the policy; its benefits package, resources and incentives; and the process of reform. 'Although we can take inspiration from Cambodia and Uganda, we should acknowledge that a financing policy favourable to poor people is much more than a mere technical issue. The policy is also about national politics, political economy, and social justice. National political resoluteness will remain the key resource to improve equity in health systems.	None
Fragile states and aid effectiveness: an expanded bibliography	Canavan and Vergeer	Working paper	2008	KIT	Provides overview of definitions used by different agencies	Literature review	General	Why donors should invest in post-conflict states; health and statebuilding; service delivery and reconstruction; aid effectiveness	There is a wealth of more general literature on service delivery in fragile or post-conflict contexts, and approaches to health system reconstruction based on lessons learned. On the other hand, there is limited literature on aid flow and on the inter-relationship between health sector development and aid effectiveness. Meanwhile, the importance of alignment, harmonisation and aid predictability is a feature of the humanitarian reform literature, World Bank reviews and selected ODI papers	More research is needed on the links between aid effectiveness and health sector development in fragile states
Post-conflict Health Sectors: The Myth and Reality of Transitional Funding Gaps	Canavan, Vergeer, Bornemiza	Report	2008	KIT for Health and Fragile States Network	A country or area is considered to be post-conflict when active conflict ceases and there is a political transformation to a recognized post-conflict government	Secondary data sources were used to map out transitional funding in six post-conflict settings. In addition, 28 interviews were conducted with key informants from donors, UN, international NGOs, the International Committee of the Red Cross and Red Crescent (ICRC) and independent experts. Information from the interviews was triangulated with key findings from the literature and country level data where available.	Afghanistan, Democratic Republic of the Congo (DRC), Liberia, Sierra Leone, Southern Sudan, and Timor Leste (formerly East Timor).	Aid funding post-conflict and its determinants	Of the six post-conflict settings analysed, two experienced no funding gap (Afghanistan and Timor Leste), three had probable funding gaps (DRC, South Sudan and Sierra Leone), and one averted a serious funding gap (Liberia). Three determinants of transitional funding for health were identified: the nature of the aid instruments, donor behaviour and policies, and a government's capacity and legitimacy. Whilst aid instruments were adapted to the transition, they did not always lead to adequate funding for health. Donor policy sometimes limited harmonization and strategic thinking, and geo-political priorities influenced the amount and timeliness of aid flows for health. Tensions between state-avoidance and state building were also important. There was very limited tracking of aid flows within the health sector which made it difficult to assess funding gaps. More aid tracking is required in these settings to allow for health actors to ensure that health services do not contract during the crucial post-conflict period, when populations are still very vulnerable.	None

Title	Author	Publication	Year	Organisation/Institution	Definition for post-conflict/fragile	Research Methods	Country/Regions	Major Themes	Main findings	Recommendations for further research
Translating knowledge into policy and action to promote health equity: The Health Equity Fund policy process in Cambodia 2000–2008	Por Ir, Maryam Bigdeli, Bruno Meessen, Wim Van Damme	Health Policy	2010	Siem Reap Provincial Health Department, Ministry of Health, Cambodia; Department of Public Health, Institute of Tropical Medicine, Belgium; Department of Health Systems, Cambodian Office of the World Health Organization	Not focussed on PC as such	We used a knowledge translation framework to analyse the HEF policy process between 2000 and 2008. The analysis was based on data from document analysis, key informant interviews and authors' observations	Cambodia	Knowledge translation, HEF as case study	The HEF policy-making process in Cambodia was both innovative and incremental. Insights from pilot projects were gradually translated into national health policy. The uptake of HEF in health policy was determined by three important factors: a policy context conducive to the creation, dissemination and adoption of lessons gained in HEF pilots; the credibility and timeliness of HEF knowledge generated from pilot projects; and strong commitment, relationships and networks among actors. Knowledge locally generated through pilot projects is crucial for innovative health policy. It can help adapt blueprints and best practices to a local context and creates ownership. While international organisations and donors can take a leading role in innovative interventions in low-income countries, the involvement of government policy makers is necessary for their scaling-up.	None
Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia	Por Ir, Dirk Horemans, Narin Souk, Wim Van Damme	BioMed Central	2010	Provincial Health Department, Ministry of Health, Siem Reap, Cambodia; Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium; Provision of Basic Health Services, Belgian Technical Cooperation, Phnom Penh, Cambodia. Provision of Basic Health Services Kampong Cham, Belgian Technical Cooperation, Kampong Cham, Cambodia	Not focussed on PC as such	Data on utilisation of voucher and HEF schemes and on deliveries in public health facilities between 2006 and 2008 were extracted from the available database, reports and the routine health information system. Qualitative data were collected through focus group discussions and key informant interviews. We examined the trend of facility deliveries between 2006 and 2008 in the three health districts and compared this with the situation in other rural districts without voucher and HEF schemes. An operational analysis	Cambodia	Vouchers, health equity funds, impact on skilled attendance	Facility deliveries increased sharply from 16.3% of the expected number of births in 2006 to 44.9% in 2008 after the introduction of voucher and HEF schemes, not only for voucher and HEF beneficiaries, but also for selfpaid deliveries. The increase was much more substantial than in comparable districts lacking voucher and HEF schemes. In 2008, voucher and HEF beneficiaries accounted for 40.6% of the expected number of births among the poor. We also outline several limitations of the voucher scheme. Vouchers plus HEFs, if carefully designed and implemented, have a strong potential for reducing financial barriers and hence improving access to skilled birth attendants for poor women. To achieve their full potential, vouchers and HEFs require other interventions to ensure the supply of sufficient quality maternity services and to address other non-financial barriers to demand. If these conditions are met, voucher and HEF schemes can be further scaled up under close monitoring and evaluation.	None
Mothers and infants to get free health care in Sierra Leone	Wairagala Wakabi	The Lancet (article)	2010	None given	Not focussed on PC as such	n/a	Sierra Leone	Removal of user fees	The introduction of free medical care for pregnant and breastfeeding mothers, as well as children younger than 5 years, could help Sierra Leone shed the unenviable reputation of having the highest maternal and child mortality rates in the world. A government report shows that the cost of delivering this strategy during 2010 will be US\$91 million, of which \$71 million has already been committed by donors and the government. One committee is addressing the need for qualified medical staff, including salaries and incentives	None

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Mothers and infants to get free health care in Sierra Leone	Wairagala Wakabi	The Lancet (article)	2010	None given	Not focussed on PC as such	n/a	Sierra Leone	Removal of user fees	The introduction of free medical care for pregnant and breastfeeding mothers, as well as children younger than 5 years, could help Sierra Leone shed the unenviable reputation of having the highest maternal and child mortality rates in the world. A government report shows that the cost of delivering this strategy during 2010 will be US\$91 million, of which \$71 million has already been committed by donors and the government. One committee is addressing the need for qualified medical staff, including salaries and incentives to compensate for the loss of income linked with free care. Another is working on the supply of drugs and other logistics, while a third one is educating health workers and the public about the free care system. Civil war between 1991 and 2002 destroyed health infrastructure in Sierra Leone, and has also been partly blamed for the acute shortage of medical workers. Last year, a report by MSF showed that patient fees acted as a major obstacle to accessing life-saving health care. Pregnant women reported long delays in getting attention and some said that they were denied care because they could not pay. Some mothers said they had been kept in hospital until their family could settle the bill. Public hospitals were charging up to \$80–\$250 for caesarean sections, placing the procedure out of reach for most women in the country.	None
Global health: will positive changes for Sierra Leone's health professionals mean the end of its Brain Drain?	J Daniel Kelly, Mohamed Bailor Barrie	Journal of Public Health Policy	2010	Baylor College of Medicine, Houston, Texas, USA; College of Medicine and Allied Health Sciences, University of Sierra Leone	Not focussed on PC as such	n/a	Sierra Leone	Brain drain and HRH	We present here examples of how Sierra Leone works to solve its health and human resource crisis. Dr Sandi wrote a 'Report on The Annual Health Review and Planning Workshop', confirming in 2007 that doctors and nurses immigrate to the United States and other countries for better salaries, postgraduate training opportunities, and improved working conditions. These problems may have become a mantra as in the Brain Drain, but Sierra Leone makes positive changes to reduce its health professional exodus. Today, Sierra Leone can raise salaries through more parastatal organizations supported by a growing financing system and redirecting health expenditures in infrastructure. Postgraduate training opportunities exist in surgery and family medicine, and as hospitals are equipped with essential medical technologies, more residency programs will be initiated in better working conditions. Meanwhile, bureaucracy is being minimized as government decentralizes its recruitment services. We anticipate that these positive changes will lead to higher retention rates of future medical graduates.	None

Title	Author	Publication	Year	Organisation/Institution	Definition for post-conflict/fragile	Research Methods	Country/Regions	Major Themes	Main findings	Recommendations for further research
Learning lessons on implementing performance based financing, from a multi-country evaluation	Jurien Toonen, Ann Canavan, Petra Vergeer, Riku Elovainio	Report	2009	KIT for Cordaid and WHO	Not focussed on PC as such	Literature review and mixed methods retrospective evaluation of CORDAID projects in five countries	Democratic Republic of Congo, Tanzania, Zambia, Burundi, Rwanda	Performance based financing in post-conflict and non-post-conflict countries	The emergence of viable institutional arrangements for PBF in fragile state contexts was noteworthy and may be due to a vacuum in the existing governance and policy environment which allows for the building of 'new' institutions appropriate to the need. On the contrary, the more stable states were found to witness greater challenges when finding a place for the local fund holder within existing institutions, for community involvement and for increased autonomy at health facility level. It may be that pre-existing institutional arrangements as found in more stable contexts are less flexible to assume extended roles and parallel modalities were therefore more in evidence.	A call is made for investigative research to study the contribution to overall health systems performance, but also significant is to uncover the issues of attribution; this can be done through longitudinal comparative studies with other health financing approaches. The methodology of introducing the PBF approach requires operational research and field-testing of different approaches to understand which one leads to the most sustainable and successful results.
Health system strengthening in Cambodia—A case study of health policy response to social transition	John Grundy, Qiu Yi Khut, Sophal Oum, Peter Annear, Veng Ky	Health Policy	2009	Nossal Institute for Global Health, The University of Melbourne, Melbourne, Australia; Communicable Diseases, Surveillance and Response, World Health Organization, Phnom Penh, Cambodia; University of Health Sciences, Cambodia; Health Sector Support Program, Ministry of Health, Phnom Penh, Cambodia	Social transition post conflict	Sources of information included a literature review, participant observation in health planning development in Cambodia between 1993 and 2008, and comparative analysis of demographic health surveys between 2000 and 2005.	Cambodia	Analysis of policy responses to 'social transition' after civil conflict and economic transition	In Cambodia there have been sharp but unequal improvements in child mortality, and persisting high maternal mortality rates. Data analysis demonstrates associations between location, education level and access to facility based care, suggesting the dominant role of socio-economic factors in determining access to facility based health care. These events are taking place against a background of rapid social transition in Cambodian history, including processes of decentralization, privatization and the development of open market economic systems. Primary policy responses of the Ministry of Health to social transition and associated health inequities include the establishment of health contracting, hospital health equity funds and public-private collaborations.	None

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Tracking Official Development Assistance for Reproductive Health in Conflict-Affected Countries	Preeti Patel, Bayard Roberts, Samantha Guy, Louise Lee-Jones, Lesong Conteh	PLoS Medicine	2009	King's College London, London; Conflict and Health Programme, London School of Hygiene & Tropical Medicine; RAISE Initiative, Marie Stopes International, London; Swiss Centre for International Health, Swiss Tropical Institute, Basel, Switzerland	Conflict-affected countries were selected as having been at "war" at a point in the period 2000 to 2006 based upon the Uppsala University Conflict Database, with additional information used from the World Bank. As the conflicts could have finished during this 5 year period, the conflict-affected countries in the study sample included countries that were either at war or in a postwar phase. War is defined as major armed conflict in which there are over a 1,000 battle-related deaths in 1 year.	The Creditor Reporting System and the Financial Tracking System databases were the chosen data sources for the study. ODA disbursement for reproductive health activities to 18 conflict-affected countries was analysed for 2003, 2004, 2005, and 2006.	18 conflict affected countries versus non-affected	Tracking of assistance for reproductive health - trends for conflict-affected versus not	An average of US\$20.8 billion in total ODA was disbursed annually to the 18 conflict-affected countries between 2003 and 2006, of which US\$509.3 million (2.4%) was allocated to reproductive health. This represents an annual average of US\$1.30 disbursed per capita in the 18 sampled countries for reproductive health activities. Non-conflict affected least-developed countries received 53.3% more ODA for reproductive health activities than conflict-affected least developed countries, despite the latter generally having greater reproductive health needs. ODA disbursed for HIV/AIDS prevention and treatment increased by 119.4% from 2003 to 2006. The ODA disbursed for other direct reproductive health activities declined by 35.9% over the same period. This study provides evidence of inequity in disbursement of reproductive health ODA between conflict affected countries and non-conflict-affected countries, and between different reproductive health activities.	The study was limited to 4 years. Additional years would help to provide a longer-term trend analysis of ODA to conflict-affected countries, and a follow-up study is planned to track ODA disbursement for reproductive health up to at least 2010
Perceived barriers to utilization of maternal health services in rural Cambodia	Sadatashi Matsuoka, Hirotsugu Aiga, Lon Chan Rasmeye, Tung Rathavy, Akiko Okitsu	Health Policy	2010	JICA	Not focussed on PC as such	A qualitative study of 66 reproductive-age women was conducted in Kampong Cham Province, Cambodia. Data were collected through 30 semi-structured interviews and 6 focus groups	Cambodia	Barriers to maternal health care	We identified 5 barriers to the utilization of maternal health services: (i) financial barriers; (ii) physical barriers; (iii) cognitive barriers; (iv) organizational barriers; and (v) psychological and socio-cultural barriers. The Cambodian Ministry of Health and its development partners should take these barriers into account when promoting the use of maternal health services. These barriers should be addressed proactively. A successful approach to increasing use of maternal health services should involve changes to both service programs and public education.	None

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Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda	Kruk, Freedman, Anglin, Waldman	Social Science & Medicine	2010	University of Michigan/AMDD/Columbia	Not given	Literature review	Various	Health sector development and statebuilding	Building on the growing literature about health systems as social and political institutions, we elaborate a logic model that outlines how health systems may contribute not only to improved health status but also potentially to broader statebuilding and enhanced prospects for peace. Specifically, we propose that careful design of the core elements of the health system by national governments and their development partners can promote reliable provision of essential health services while demonstrating a commitment to equity, strengthening government accountability to citizens, and building the capacity of government to manage core social programs. We review the conceptual basis and extant empirical evidence for these mechanisms, identify knowledge gaps, and suggest a research agenda.	While the importance of health systems as social and political institutions has support in both theory and empirical studies, the magnitude of the effect of a well functioning health system on statebuilding and promoting peace in a post-conflict country where many other rebuilding priorities appear equally as urgent is not known. Despite growing international focus and large financial commitments to post-conflict countries, there is only fragmented data on the best timing of health system rebuilding and the most effective approaches for tailoring programming to local circumstances to guide donor development policy. Cross-disciplinary research is urgently needed in this area. In particular, health policymakers need to adopt new indicators designed to measure the social and political impacts of the health system that can be feasibly implemented in a resource constrained post-conflict setting. If rigorous and reproducible evidence supports the mechanisms presented here, investing in health systems can become an important strategy to hasten the rebuilding of societies and redress the suffering of populations affected by violent conflict.
Availability of essential health services in post-conflict Liberia	Margaret E Kruk, Peter C Rockers, Elizabeth H Williams, S Tornorlah Varpilah, Rose Macauley, Geetor Saydee & Sandro Galea	Bulletin of the WHO	2010	Mailman School of Public Health, Columbia University, New York, USA; Harvard School of Public Health, Boston, Massachusetts, USA; John Snow, Inc., Monrovia, Liberia; Republic of Liberia Ministry of Health and Social Welfare, Monrovia, Liberia; Basic Support for Institutionalizing Child Survival, Monrovia, Liberia; Institute of Population Studies, University of Liberia, Monrovia, Liberia	None given	We carried out a population-based household survey in rural Nimba county and a health facility survey in clinics and hospitals nearest to study villages. We evaluated access to facilities that provide index essential services: artemisinin combination therapy for malaria, integrated management of childhood illness, human immunodeficiency virus (HIV) counselling and testing, basic emergency obstetric care and treatment of mental illness.	Liberia	Availability essential services; Liberia	All respondents could access malaria treatment at the nearest facility and 55.9% could access HIV testing. Only 26.8%, 14.5%, and 12.1% could access emergency obstetric care, integrated management of child illness and mental health services, respectively. Although there has been progress in providing basic services, rural Liberians still have limited access to life-saving health care. The reasons for the disparities in the services available to the population are technical and political. More frequently available services (HIV testing, malaria treatment) were less complex to implement and represented diseases favoured by bilateral and multilateral health sector donors. Systematic investments in the health system are required to ensure that health services respond to current and future health priorities.	None

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Poverty, vulnerability, and provision of healthcare in Afghanistan	Trani JF, Bakhshi P, Noor AA, Lopez D, Mashkoo A	Social Science & Medicine	2010	UCL	Fragile states & complex environments; not defined	Nationwide survey carried out in 2005; analysed by logistic regression	Afghanistan	Basic package and increase in accessibility of care	Our results indicate that the implementation of the package has partially reached its goal: to target the most vulnerable. The pattern of use of healthcare provider suggests that disabled people, female-headed households, and poorest households visited health centres more often (during the year preceding the survey interview). But these vulnerable groups faced more difficulties while using health centres, hospitals as well as private providers and their out-of-pocket expenditure was higher than other groups. In the model of provider choice, time to travel reduces the likelihood for all Afghans of choosing health centres and hospitals. The 'scaling-up process' is faced with several issues that jeopardize the objective of equitable access: cost of care, coverage of remote areas, and competition from profit-orientated providers. To overcome these structural barriers, we suggest reinforcing processes of transparency, accountability and participation.	None
Promoting health equity in conflict-affected fragile states	Bornemisza O, Ranson MK, Poletti TM, Sondorp E	Social Science & Medicine	2010	London School of Hygiene and Tropical Medicine	Conflict-affected (during and post)	The methods employed are a review of the published and grey literature, key informant interviews and an analysis of data on social determinants of health indicators	General	Health equity and conflict affected states; conceptual framework on types of inequity; factors influencing equity; strategies to address	Issues around health equity in conflict-affected fragile states have received very little analysis to date. This paper examines the main factors. A new conceptual framework was developed outlining types of inequity, factors that influence equity and possible strategies to strengthen equity. Factors that affect equity include displacement, gender and financial barriers. Strategies to strengthen health equity include strengthening pro-equity policy and planning functions; building provider capacity to provide health services; and reducing access and participation barriers for excluded groups. In conclusion, conflict is a key social determinant of health.	More data is needed to determine how conflict affects within-country and between-country equity, and better evaluated strategies are needed to reduce inequity.

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Targeting accuracy and impact of a community identified waiver card scheme for primary care user fees in Afghanistan	Steinhardt, L. and Peters, D.	International Journal for Equity in Health	2010	Johns Hopkins Bloomberg School of Public Health	Fragile - underfined	Community-based targeting of vulnerable households was piloted in Afghanistan and evaluated for its feasibility, accuracy and effect on care-seeking. Waiver cards were distributed to very poor and female-headed households in catchment areas of 26 facilities in 10 provinces of Afghanistan in 2005 as one component of a larger health financing study. Households were nominated by community leaders using general guidelines to support 15% of the poorest members. In most cases, waiver cards were pro-actively distributed to them. Targeting accuracy, perceptions, as well the cards' effects on utilization were evaluated in 2007 through household surveys, health facility data, and in-depth interviews and focus group discussions with facility staff and community leaders.	Afghanistan	Community-based targeting of exemptions for user fees, primary care	The waiver system was implemented quickly at all but one facility charging fees. Facility staff and community leaders reported favorable perceptions of plementation and targeting accuracy. However, an analysis of the asset index of beneficiaries indicated that although targeting was progressive, significant leakage and high levels of under-coverage occurred; 42% of cards were used by people in the wealthiest three quintiles, and only 19% of people in the poorest quintile received a card. Households with waiver cards reported higher rates of care-seeking for recent illnesses compared to those without cards (p = 0.02). Conclusions: Community identification of beneficiaries is feasible in a fragile state.	None
Engagement with Non-State Service Providers in Fragile States: Reconciling State-Building and Service Delivery	Batley, R. And McLoughlin, C.	Development Policy Review	2010	University of Birmingham for DFID	We recognise that the term 'fragile states' is contested. Here we use the term to refer to states which are 'unable to meet [their] population's expectations or manage changes in expectations and capacity through the political process' (OECD, 2008)	Literature review	General	Non-state services, fragile states, state-building	Governments and donors are faced with difficult strategic choices about how to deploy their limited capacity for engagement with NSPs most effectively, and without risk to pro-poor or pro-service outcomes. In fragile or conflict-affected settings, there is an overriding international goal of supporting state-building. There is no meaningful way of resolving these alternative priorities by deciding which of the possible functions (policy-making, regulation, contracting or direct service delivery) would be more inclined to build states, and then trying to bring them about regardless of capacity and context. The better approach is to accept that undertaking any of these functions can be a state-building activity, and then to identify, in the particular country context, which, if any, mode of engagement would most enable improved service provision, be most feasible in terms of capacity and willingness to undertake them, and present the lowest risk of failure and damage to non-state service provision.	None

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Health Aid Governance in Fragile States: The Global Fund Experience	Olga Bornemisza, Jamie Bridge, Michael Olszak-Olszewski, George Sakvarelidze, and Jeffrey V Lazarus	Global Health Governance	2010	Global Fund	Fragile state defined as one that "cannot or will not deliver core functions to the majority of its people, including the poor"	This study analyzes Global Fund grant data from 122 recipient countries as an initial exploration into how well these grants are performing in fragile states as compared to other countries.	General	Global health initiatives and fragile states; capacity and performance	Since 2002, the Global Fund has invested nearly US\$ 5 billion in 41 fragile states, and most grants have been assessed as performing well. Nonetheless, statistically significant differences in performance exist between fragile states and other countries, which were further pronounced in states with humanitarian crises. This indicates that further investigation of this issue is warranted: variations in performance may be unavoidable given the complexities of health governance in fragile states, but may also have implications for how the Global Fund and others provide aid. For example, faster aid disbursements might allow for a better response to rapidly changing contexts, and there may need to be more of a focus on building capacity and strengthening health governance in these countries.	Further exploration, including multivariate analyses and fieldwork, is required in order to better assess the implications for the Global Fund, its partners and other stakeholders, and to inform discussions about potential responses and actions that need to be taken.
From drought to deluge: how information overload saturated absorption capacity in a disrupted health sector	Beesley, Cometto, Pavignani	Health Policy and Planning	2011	WHO	Disrupted health sector (not defined)	Reflections of authors on the process of developing an HRH plan	South Sudan	Technical assistance and its limits in a context of low capacity	The survey shed new important evidence on the human resources situation in southern Sudan, both in quantitative and qualitative terms, and formulated specific recommendations. The formulation of the human resources plan, however, took another direction, apparently unrelated to the findings of the survey. Various factors contributed to the scope and methodology of the survey being inappropriate to the reality of southern Sudan. In the presence of systemic capacity gaps, including uncertain governance and precarious management systems, the benefit of one-off comprehensive surveys is likely to be negligible. Inaction is not always rooted in the lack of information, as too often assumed; this case study exposes the limits of a rationalistic approach to policy formulation and planning in the field of human resources for health. An alternative approach that entails incremental steps to institutional capacity building is suggested.	None

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Case study of health sector reform in Kosovo	Percival and Sondorp	Conflict and health	2010	Carlton University, Canada	Not focussed on PC as such	Document review and stakeholder interviews	Kosovo	This paper develops a framework for analyzing health reform in postconflict settings and applies it to Kosovo	The paper examines two questions: first, the selection of health reform measures; and second, the outcome of the reform process. It measures the success of reforms by the extent to which reform achieved its objectives. The paper demonstrates that the external nature of the reform process, the compressed time period for reform, and weak state capacity undermined the ability of the success of the reform program.	None
Global Health Cluster Position Paper: Removing User Fees for Primary Healthcare Services during Humanitarian Crises	Global Health Cluster; Inter-Agency Standing Committee	Prehospital and disaster medicine	2010	WHO	Applies to conflict period (but by definition could extend recommendations to post-conflict?)	Policy statement	General	User fees in conflict period	Statement of international consensus that fees for PHC services should be suspended during conflict; donors should be supportive and evidence of good practice should be collected	None
Health sector recovery in early post-conflict environments: experience from southern Sudan	Commetto, Fritsche, Sondorp	Disasters	2010	None	None given	Interviews, literature review, personal experience	South Sudan	Health sector reform post-conflict; international actors as drivers of change	Lessons learned from the southern Sudan case include the need for: sustained investment in assessment and planning of recovery activities; building of procurement capacity early in the recovery process; support for funding instruments that can disburse resources rapidly; and streamlining the governance structures and procedures adopted by health recovery financing mechanisms and adapting them to the local context	None

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Rebuilding and strengthening health systems and providing basic health services in fragile states	William Newbrander, Ronald Waldman and Megan Shepherd-Banigan	Disasters	2011	MSH	Although there are many descriptions of fragile states, the two criteria on which they are judged are legitimacy—government will and capacity to provide core services and basic security—and effectiveness in providing services and security. The forms of state fragility in one typology are (1) deteriorating state, (2) collapsed state, and (3)	Review article	Afghanistan, DRC, Liberia	Fragile states, health system strengthening, humanitarian relief work, rebuilding health care systems, urgent health needs, war	The international community has compelling humanitarian, political, security and economic reasons to engage in rebuilding and strengthening health systems in fragile states. Improvements in health services and systems help to strengthen civil society and to restore legitimacy to governments. Effective engagement with fragile states to inform the design of health programmes and selection of interventions depends on donor coordination and an understanding of health system challenges. Support should always combine short-term relief with longer-term development. Stakeholders should aim not only to save lives and protect health but also to bolster nations' ability to deliver good-quality services in the long run.	None
Post-conflict health reconstruction: search for a policy	Rubenstein, S.	Disasters	2011	Johns Hopkins Bloomberg School of Public Health	Post-war	Review article	General	equity, human rights principles, legitimacy, post-conflict health reconstruction, security, stabilisation	Despite increasing experience in health reconstruction in societies emerging from conflict, the policy basis for investing in the development of equitable and effective health systems in the wake of war remains unsettled.(1) Consideration of post-conflict health reconstruction is almost entirely absent in donor policies on global health. Practically by default, health programmes are seen increasingly as an element of stabilisation and security interventions in the aftermath of armed conflict. That perspective, however, lacks an evidence base and can skew health programmes towards short-term security and stabilisation goals that have a marginal impact and violate the principles of equity, non-discrimination, and quality, which are central to sound health systems and public acceptance of them	None
Moving towards a sector-wide approach (SWAp) for health in fragile states	Ines Rothmann, Ann Canavan, Danny Cassimon, Anne Coolen, Karel Verbeke	Working paper	2011	KIT	Not defined	Based on literature review and three country case studies	Timor Leste, Sierra Leone and Democratic Republic of Congo	SWAPs in post-conflict settings - their feasibility, desirability and how to enhance their implementation	Findings from the field studies highlight that SWAp is not a universally endorsed approach and, consistent with findings in more stable contexts, it is indeed an iterative process and not a panacea that will resolve fragmentation and incoherence. Given the complexity of the ways in which post-conflict aid architecture interacts with mixed motivations, attention to both process and mechanisms for improved partnership and coordination are key to achieving better results	None

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Measuring and decomposing socioeconomic inequality in healthcare delivery: A microsimulation approach with application to the Palestinian conflict-affected fragile setting	Mohammad Abu-Zaineh, Awad Mataria, Jean-Paul Moatti, Bruno Ventelou	Social Science & Medicine	2011	INSERM, University of the Mediterranean, Marseille; Birzeit University, Patestine; WHO-EMRO; CNRS-GREQAM-IDEP, Marseille	Conflict-affected (during and post)	Microsimulation	West Bank and Gaza strip	Equity in utilisation of health care	Results suggest that the worse-off do have a disproportionately greater need for all levels of care. However with the exception of primary-level, utilisation of all levels of care appears to be significantly higher for the better-off. The microsimulation method has made it possible to identify the contributions of factors driving such pro-rich patterns. While much of the inequality in utilisation appears to be caused by the prevailing socioeconomic inequalities, detailed analysis attributes a non-trivial part (circa 30% of inequalities) to heterogeneity in healthcare-seeking behaviours across socioeconomic groups of the population. Several policy recommendations for improving equity in healthcare delivery in the occupied Palestinian territory are proposed.	Further research is clearly required to fully comprehend the factors underlying heterogeneity in behaviours per se and to developing and implementing pro-equity policy interventions as per the two parts of the oPt
Health System Reconstruction: Can it Contribute to State-building?	Jack Eldon, Catriona Waddington, Yasmin Hadi	Paper for Health and Fragile States Network	2008	HLSF London	Together, capacity, institutions, legitimacy, resources and effective processes to support a social compact combine to produce 'resilience'. We use the term resilience to mean the ability of states to withstand and adapt to stress in ways that maintain a creative relationship between state and society. Some states without a strong state society compact may be able to recover from stress, at least in the short-term. However, if a state has to rely on violence rather than political processes to maintain stability then its legitimacy is at least questionable, and states with weak legitimacy are unlikely to remain resilient in the longer term. They must either adapt to the changing demands of society for a reshaped social compact, or be overtaken by social, economic and political change. A fragile state is one that lacks some or all of the characteristics of a resilient state.	We combined the existing expertise of the authors in health systems and governance with a brief desk-study involving a literature review, and telephone and face-to-face interviews with sixteen health and governance policymakers and practitioners. We then explored the interactions between health systems reconstruction and state-building through two case studies, Nigeria and Sierra Leone, using local researchers to undertake the fieldwork.	General, but with case studies (Sierra Leone and Nigeria)	Health systems and state-building in fragile countries	It was found that health sector strengthening can contribute to state building in the health sector. It can help build legitimacy and capacity, and put health on the statebuilding agenda. The impact of health sector interventions on wider state-building is unclear. There may be more scope for wider state-building and strengthening the state-society compact through decentralized and 'bottom up' approaches, though this needs to be verified through further study	Principal questions for further research include: 1. What is the role of health systems strengthening on wider state-building in terms of: a) enhancing institutional capacity for stewardship, oversight, and policy enforcement; and b) enabling greater state credibility and legitimacy? 2. What are the state-building links of the relatively 'overlooked' or un-studied health sector building blocks such as the information system in fragile states? 3. Does improving voice and accountability in the health system contribute to strengthening the social compact between citizens and the state? 4. Does improving the effectiveness and transparency of resource management (both financial and human) in health contribute to greater trust in the state? 5. How does health system strengthening contribute to capacity development in other state institutions, ministries and sectors? 6. Does devolved health service delivery contribute to state-building at the local level? 7. Can building the capacity of the local state create pressures for more responsive and accountable central government?

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Health in fragile states: case study Northern Uganda	Rowley, E.	Report	2006	BASICS, USAID	As per Newbrander 2006	Not described but appears to be based on literature reviews and interviews	northern Uganda	Capacity of main stakeholders and lessons learned from responses to date	Develops some key principles for donor engagement	None
Providing Health Services in Fragile States	Newbrander, W.	Report	2006	BASICS, USAID	Although there are many descriptions of fragile states, the two components they have in common are legitimacy — government will and capacity to provide core services and basic security—and effectiveness in providing services and security.	Summary of lessons learned in case study countries - Guatemala, Nepal, Côte d'Ivoire, Democratic Republic of Congo, southern Sudan, northern Uganda, Lao People's Democratic Republic, Papua New Guinea and Kyrgyzstan	General	Health system development and health service delivery in fragile states - challenges and lessons, including for donor engagement	Develops some key principles for donor engagement	None
Non-state providers, the state, and health in post-conflict fragile states	Commins, S.	Development in Practice	2010	University of California	Different definitions are discussed, focussing on OECD DAC fragile states group approach	Review of the field, drawing on two case studies from literature	General, but with case studies (Afghanistan and South Sudan)	Non-state services, fragile states, state-building	A key for building competent and accountable public health institutions resides in ensuring that the state has a broad and effective oversight of the health sector. Given the difficulties with the different instruments and organisations aligning in Southern Sudan, a key point is that in most fragile states there will be a continuing dynamic between reducing immediate vulnerability; achieving specific health outcomes; building a more lasting and equitable health system; and building the capacity of civil society to monitor services, holding both NSPs and government service providers to account.	None
Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected Fragile States	Alliance for Health Policy and Systems Research	Report	2008	AHPSR	This paper uses the World Bank's 2007 list of 34 fragile states	Desk review	General	Identifying research priorities and gaps in relation to health systems in fragile countries	There is a scarcity of research into their health systems, and on how to work effectively within their governance and resource constraints, despite the fact that more effective health services are urgently needed. While research can be high risk due to security and governance concerns, the yields, in terms of contributing to substantial improvements in health systems strengthening, and improvements in health service delivery and health outcomes, justify the investment. Lessons from innovations in post-conflict states can also be applied to health service delivery in more stable, low-income countries.	Innovations in the organization and management of health service delivery and financing in conflict-affected environments should receive more substantial health policy and systems research. More research is also needed on the effectiveness of aid with respect to the health system, and the links between health, governance, and state building.