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Policy **Position**

No Short Cuts

The Difficult Path to Maternal, Newborn and Child Health in Fragile States

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Cover image: A Community Health Worker in Niger. They work in communities to support mothers with their babies and they are able to refer malnourished children and mothers to health centres. © 2012 Mariana Chokaa/World Vision

Above: A child in East Timor visiting a health clinic, supported by World Vision in conjuction with the government. The World Vision project has been working in the community for over 2 years. © 2011 Rohan Zerna & Jacqui Hocking/World Vision.

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Introduction

The challenges faced by fragile and conflict affected states have been drawing attention by various think tanks, donors and stakeholders in recent years[1] . World Vision is particularly concerned about the often voiceless causalties of war, marginalised communities, women and children. There is a clear relationship between fragile states and poor Maternal, Newborn and Child Health (MNCH) indicators. This may not be linear, but according to WHO statistics all but one of the 15 countries worldwide with the highest neonatal mortality has recently experienced, or is in the midst of, a civil conflict.[2]

The burden of mortality among women and children in fragile states is large. **A child born in a fragile state is twice as likely to die before their fifth birthday as a child born in a more stable low income country; and they are five times more likely to die before their fifth birthday as a child in a middle income country. On average in fragile states 140 children die per 1000 live births.** Progress on reducing these deaths is slow, and in some cases, going backwards. Fragility and conflict has a dramatically negative impact on levels of child mortality, but stability does not automatically guarantee a reduction.

These mothers and children are not dying of unknown or unique causes. They are still dying from largely preventable causes, for instance, during childbirth or immediately after, due to pneumonia, diarrhoea and from malaria. Stakeholders know how to combat these causes of death, with a well researched and documented set of interventions.

Fragile States

Through this paper, in alignment with World Vision's definition, fragile states are those where a government cannot or will not act on its responsibility to protect and fulfil the rights of the majority of the population, particularly the poor. These responsibilities include territorial control, security, public resource management, service delivery and livelihoods support. Fragility does not conform to state borders and relatively stable states may encompass fragile regions. Conversely, fragile states can contain zones of stability. Ultimately, basic accountability relationships between governments and citizens in fragile states are weak or broken.

Many fragile states are post-conflict countries, which tend to suffer from high rates of relapse to conflict, with a 44 per cent chance of a return to conflict within five years. Conflict has very severe effects on economic growth; therefore most conflict-affected fragile states have growing levels of extreme poverty, which is opposite to the trend in most low income countries. Many fragile states also endure cyclical natural disasters e.g. floods, drought, earthquake, tropical storms etc. making the contexts so much more unpredictable and fragile. Fragility can be short-lived, but in most instances it becomes a protracted crisis and lasts for many years. Poor governance contributes to a breakdown of infrastructure, which quickly loses key equipment, supplies and qualified personnel, and these losses become more severe over time.

[1] UK HMG, *Building Stability Overseas Strategy*, (HMG, 2011).
[2] Debarati Guha-Sapir and Olivia D'Aoust *World Development Report 2011: Background paper on demographic and health consequences of civil conflict*, (World Bank, 2010).

This paper is building on World Vision's experience in fragile states; interviews with government officials, country case studies, particularly from Pakistan, DRC and South Sudan; and research on health system strengthening in fragile states.[3] It argues that without a focus on building the health systems, programmes targeting a reduction in Maternal Newborn and Child mortality will only see temporary improvements. World Vision believes that a focus on building, strengthening and supporting the weaker health systems in fragile states is critical to providing long-term and sustainable results.

Fragile states are exceptionally challenging to work in and it is much easier to focus on direct interventions which produce short-term and tangible results. However, this paper argues that such approaches can limit the long-term impact of aid in fragile states. In addition, that whilst working with governments at all levels to build health systems can be difficult and frustrating in the short-term, the results can be very beneficial, particularly for the often excluded, in the long-term.

World Vision has done extensive work on how to approach health systems strengthening in fragile states and has published research on the topic.[4] This paper will not go over old ground, but rather focus on blockages that stop donors and Non-Governmental Organisations (NGOs) from effectively supporting health systems strengthening in fragile states.

Whilst by no means claiming that these are comprehensive solutions to the complex problem, we argue that:

1. DFID should recognise the importance and difficulties of achieving results in these contexts and look to further incentivise long-term action in fragile states by developing a "fragility premium" for results achieved there;
2. Donors, including DFID, should institute longer term and predictable funding cycles in order to allow for effective health systems strengthening;
3. Global Health Partnerships should develop specific fragile state policies or strategies in order to ensure an integrated approach to health systems strengthening in fragile states; and
4. NGOs should use their capacity and expertise to strengthen sub national and local health systems and policies

[3] The primary emphasis of the research is based on case studies in Democratic Republic of Congo and Pakistan. In order to collect information, we spoke to local actors, conducted stakeholder interviews and used information from World Vision "Child Health Now" assessment reports; and Annemarie ter Veen and Stephen Commins, *From Services to Systems: Entry points for donors and nonstate partners seeking to strengthen health systems in fragile states*, (World Vision Canada, 2011)
[4] ter Veen & Commins, *From Services to Systems*

Left: A nurse with a newborn child at the maternity unit of Herat hospital, Afghanistan. It is a 100 bed facility serving a patient population of nearly 2 million people. Approximately 1,600 babies are delivered in the hospital every month, often with complications.
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Worse than bullets – the challenge of MNCH in Fragile States

While much attention is given to deaths caused by conflict, it is important to note that civilian mortality in states experiencing violent conflict is mostly due to non-violent causes. Constituting the most vulnerable part of any population, women and adolescent girls and children under 5 experience the greatest proportion of deaths in fragile states. **Over 80% of deaths in 2003-2008 in Darfur were due to disease, not violence[5], and in DRC, only 4 percent of 5.4 million excess deaths in civilians were due to conflicts occurred as a result of direct violence.[6]**

[5] Degomme, O. and Guha-Sapir, "Patterns of mortality rates in Darfur conflict", The Lancet, (Vol. 375, 2010)
[6] IRC, *Mortality in the Democratic Republic of the Congo: an ongoing crisis*, (IRC, 2007): http://www.rescue.org/sites/default/files/migrated/resources/2007/2006-7_congomortalitysurvey.pdf

DFID, the High Level Forum on the MDGs, and the World Development Report 2011, have demonstrated that fragile states account for:

- A third of the people who live in absolute poverty
- A third of the undernourished children, with twice the levels of undernutrition as developing countries
- A third of the maternal deaths
- Nearly half of the under-5 deaths
- A third of people living with HIV/AIDS in developing countries, and
- Two thirds of disease epidemics

Sources: http://www.dfid.gov.uk/Pubs/files/fragilestates-paper.pdf and http://wdr2011.worldbank.org/fulltext

The burden of mortality among mothers and children in fragile states is disproportionately large when compared with more stable states – see box. Progress towards Millennium Development Goal 4 (MDG 4)has been slowest in these contexts and no fragile or conflict-affected country even likely to achieve a single MDG[7]. **The child mortality rate in low and middle income countries was 56 per 1000 live births in 2010, while in low-income fragile states, child mortality was nearly 150% higher—around 140 per 1000.**[8] A study conducted in the DRC in 2006-7 found that 47 per cent of mortality occurred among children under the age of five, even though they comprised only 19 per cent of the total population.[9]

With regards to MDG 5 on reducing maternal mortality, post-conflict states such as **South Sudan, Sierra Leone, Liberia and Afghanistan rank amongst the top 10 countries with the poorest maternal health indicators in the world**. Pakistan and the DRC, due to their large populations and high maternal mortality rates, are ranked second and sixth, respectively, on the list of 21 countries with the largest total number of maternal deaths in 2008.[10]

It is not surprising that the duration of the conflict is directly associated with increased and more persistent mortality among mothers and children and the effects also seem to persist during the post-conflict period. In a typical five-year war, it was found that infant mortality increased by 13%, and in the first five years of post-conflict peace the infant mortality rate remained 11% higher than the pre-conflict baseline.[11] This is corroborated by the fact that two thirds of the countries in which child mortality has actually increased since 1990 have experienced a protracted crisis, notwithstanding the international assistance they have received in support of achieving the MDGs.[12]

Opposite: Children playing outside a nutrition project, where women and children are educated about health and nutrition practices for them and their families. © 2012 Paul Bettings/World Vision

[7] World Bank, *World Development Report 2010*, (World Bank, 2011)
[8] USAID and Basics, *Fragile States*: http://www.basics.org/reports/FinalReport/Fragile-States-Final-Report_BASICS.pdf (Accessed 9 November 2012)
[9] IRC, *Mortality in the Democratic Republic of the Congo*
[10] Margaret C Hogan et al., "Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5", The Lancet, (Vol. 375, 2010)
[11] Hoeffler, Anke, and Martha Reynal-Querol. *Measuring the Cost of Conflict*, (Oxford University 2003)
[12] David Nabarro, *The ultimate challenge: sustaining life in fragile states*, presentation given at the High level forum, Abuja, (2004)

Long-term approaches to Maternal, Newborn and Child Health in Fragile States

It is well known that a package of evidence-based, high-impact, cost-effective interventions delivered at different levels of the household-to-facility continuum of care can dramatically reduce child and maternal deaths.[13] However, the impact of fragility in many states or sub-national regions has led to a near or total collapse of health systems and the health services that should deliver this package of interventions – particularly for poor, vulnerable and marginalised groups.[14]

Experiences of World Vision health programme staff working in and with MNCH projects in fragile states identified several circumstances and challenges that persist in fragile states and that need to be taken into account when operating in fragile environments.[15] These can be grouped as issues of policies and systems, social determinants of health and security. This paper focuses on the issues highlighted under policies and systems and include:

- Ill-defined health policies and lack of reliable health data
- Fragmented and damaged health infrastructure and poor institutional capacity of health systems
- Challenge with recruitment and retention of a qualified health workforce
- Lack of consistent strategies by both states and international communities on long-term core interventions
- Deteriorating skills and capacity of training institutions
- Financial constraints
- Medical Fees at point of access
- Poor medical facilities

DFID should be commended for prioritising aid to fragile states[16], as a welcome recognition of the realities of the disproportionate burden of mortality and intractability of the causes of maternal and child mortality in fragile states form part of the rational for this; along with the more politically domestic rational that fragile states are a security risk for the UK.[17]

[13] World Vision, *Child Health Now: Together we can end preventable deaths*, (World Vision, 2009)
[14] ter Veen & Commins, *From Services to Systems*
[15] Model based on contribution from participants (including from Afghanistan and Pakistan) during a World Vision workshop to develop programme guidance for MNCH in Fragile Contexts
[16] DFID, What We Do: *Governance and Conflict:* http://www.dfid.gov.uk/What-we-do/Key-Issues/Governance-and-conflict/ (Accessed 9 November 2012)
[17] HMG, *Building Stability Overseas Strategy*

Recommendation 1: DFID should incentivise long-term action in fragile states by developing a "fragility premium" for results achieved there

It should be stated upfront that working in the most fragile states is exceptionally difficult: hard fought development gains can be wiped away in the space of weeks or even days, there is a significant risk of corruption, poor physical infrastructure makes communication and transport a significant challenge; population movement and internal displacement can make it impossible to sustain success; and problems resulting from weak governance can frustrate the most patient development professional. These challenges are well known and documented, not least by World Vision.

The lack of government capacity in conflict-affected regions leads to a breakdown of the health infrastructure, basic equipment and supplies. Qualified and capable health staff often leave conflict affected regions to escape insecurity, creating a human resource drain in the areas of greatest need for health service provision. When countries finally emerge from prolonged violent conflict, their health systems are frequently in a dilapidated condition. The country's citizens have experienced increased mortality and morbidity rates, declines in the capacity of their health systems, and often drastic population displacement. Most of the normal infrastructure and facilities of an effective state are either wrecked or broken down. Poor MNCH outcomes are the results of systemic breakdowns, poor infrastructure, broken supply chains, weak leadership from health ministries, lack of health financing and the major access barrier of user fees. Add to this a poorly trained and disincentivised health workforce and a lack of a reliable health information system; it is not surprising that the health outcomes in fragile states are so poor for mothers and children.

In DRC the impact of war on the fragility of health services has been huge. The fragility drivers include, lack of roads and access due to insecurity resulting in isolation of locations due to no infrastructure. Medical hospitals and facilities have been destroyed and razed requiring complete reconstruction. Procurement systems and access of medical drugs and supplies are difficult at best and expensive. With dysfunctional government and no social services available and when there are health workers, they are not paid. The poor do not have the income needed to provide for needed drugs and health services. There is significant evidence that local populations barter in kind for the services available.

There is no simple solution to this. It is an unavoidable conclusion that results are harder to achieve in these contexts. DFID, with the focus on results, should be more upfront with this fact. Similarly, development agencies, including NGOs like World Vision, cannot promise to achieve similar levels of results in fragile states as are achieved in more stable contexts.

The current discourse centres on value for money and results-driven investment and carries a danger of disincentivising a longer term and systems focused approach in fragile states. Although there is a clear benefit in being able to demonstrate the value for money and impact of aid in

any context, long-term systems changes carry risk in fragile states and it is therefore difficult and harder to demonstrate the same results as in stable contexts in a sustainable manner. Furthermore, there has been concern raised that overemphasising short-term results can have a negative impact on aid effectiveness.[18]

As a way of squaring this circle, ***World Vision recommends that DFID develops a comprehensive and context appropriate understanding of value for money for MNCH and broader health work in fragile and conflict affect states. This should include a greater weighting of results if the programming environment is considered more risky and an inclusion of process indicators and valuable outcomes in these contexts.***

In essence increasing the weighting given to results achieved in fragile states would ensure that the difficult to reach and vulnerable are valued equally to the "low hanging fruit" of development. In the same way that the "pupil premium"[19] recognises the higher costs of reaching poorer and more vulnerable children in the UK education system, a "*fragility premium*" in DFID's results frameworks could help to level the playing field for fragile states.

'Success of projects depends upon opportunity to manage, motivation to manage, ability to manage'. The elected representative has all but the 'ability to manage', government set up does not have 'motivation to manage' and private sector does not have 'opportunity to manage'. Most of the health facilities will not be sustained due to lack of this ownership. Instead of giving funds and setting up new structures, and spending so much money on this, give that to the government". **Civil society respondent, Pakistan**

In fragile states undergoing significant health reforms, the role of the health ministry is often limited to that of policy formation and oversight, whilst donors place funding for service delivery in the hands of non-state providers, such as NGOs. This is the case in DRC, where DFID have invested significant funds in NGOs to deliver services.[20] Low government involvement in service delivery is a significant difference from non-fragile contexts, where the ministries are expected to deliver both policy and services. Whilst it should be recognised that DFID do invest in central government capacity building, with advisers in many fragile states supporting long-term centralised policy decision making, it is critical that greater support is given to the sub national and local level. Central state policy decisions need to be better reflected in the policy and practice of sub national and local level health departments. For example, South Sudan's newly developed health policy needs to be reflected in sub

[18] Javier Pereira and Carlos Villota, *Hitting the target? Evaluating the effectiveness of results-based approaches to aid*, (Eurodad 2012)
[19] Department of Education, *Introduction to the Pupil Premium*: http://www.education.gov.uk/schools/pupilsupport/premium/b0076063/pp (Accessed 9 November 2012)
[20] For example, the largest DFID grant in DRC (a health grant of £184m over its lifetime) is to NGOs: DFID project database: http://projects.dfid.gov.uk/project.aspx?Project=202732 (Accessed 9 November 2012)

national health ministries, ministries that have barely any capacity and rely heavily on NGOs.[21]

The "New Deal for Fragile States", endorsed by most donors, including DFID, at the Fourth High-Level Forum on Aid Effectiveness in Busan, states the importance of developing legitimate political processes.[22] The involvement of women and children in these processes can be strengthened when they have a say in the delivery of services and in the shape of policies and strategies.

An increasing number of governments in fragile states are developing and implementing, with various levels of success, national health strategies/plans. In DRC, the government has an active strategy for the decentralisation and reinforcement of health structures. This structure engages with the health institutions functioning on the ground in rural areas. In addition, the Ministry of Health has developed an agreed minimum package of interventions and developed an agreed list of required supplies and drugs. This assures that the integrated package of interventions from one health zone to another should be the same. As expected, a key challenge to the successful delivery of such packages is the lack of long-term funding through governments, as addressed under the next recommendation, as well as weak information systems to enable decision making and accountability for results.

Background information for this paper revealed that in Pakistan, health information systems are fragmented and vertical. They either respond to or serve primarily the health programmes that created them or are inaccurate. Health indicator data collated through various systems may be duplicated sometimes with conflicting results. Data generation is at times manipulated to serve special interests compromising the robustness of the data collation systems, discouraging data sharing or exchange and losing trust of stakeholders. District managers seldom have adequate capacity to analyse and utilise the local information appropriately. Capacity needs to be built at district, provincial and federal levels for more accurate and reliable data to aid planning and monitoring and evaluation of health services.

World Vision recommends that:

- DFID develops a comprehensive and context appropriate understanding of value for money for MNCH and broader health work in fragile and conflict affect states. This should include a greater weighting of results if the programming environment is considered more risky and an inclusion of process indicators and valuable outcomes in these contexts.

- National and International actors, including through South to South cooperation, should invest in processes in Fragile States that support strong policy and information systems at National, Sub national and local levels.

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[21] Indeed, South Sudan a good example of where government health policy is undermined by development actors. Despite government policy against user fees, a proposed World Bank programme in two states included their re-introduction. Fortunately, this was highlighted and prevented, but it shows how effectively donor policy can undermine national policy at the regional and local level. Reported by Oxfam: *Oxfam, Evidence to IDC on Fragile States*: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmintdev/1570/1570vw10.htm
[22] *A New Deal for Engagement in Fragile States*, http://www.oecd.org/international%20 dialogue/49151944.pdf

Recommendation 2: Donors, including DFID, should institute longer term funding cycles in order to allow for effective health systems strengthening

Without consistent and predictable support, allied with a higher threshold of risk, supporting the development of good policies and building health systems is a major challenge. Humanitarian actors play a key role in addressing acute emergencies, but a wide body of research also points to the need to develop and strengthen legitimate, national institutions in order to break persistent cycles of violence and embed sustainable peace. Otherwise the humanitarian

> The health interventions in Eastern DRC which is affected by insecurity and less stability often find themselves under a humanitarian banner. Humanitarian health provides limited emergency health services using high cost expatriate staff which can be important for a time. Developmental health services capacitate local communities to enable them to manage good health outcomes most often managed by national staff. Humanitarian health services often do not provide some very important developmental aspects of integrated health services such as family planning, MNCH, training, improving water sources reconstruction of infrastructures and equipment and supplies. In addition, the cost of interventions from an expat driven humanitarian staffing model reduces the percentage of the resources available for community health services strengthening approach. As a rule of thumb, one practitioner shared that no more than 50% of the intervention budget should be for staff support. He states that he always tries to keep the amount near 25% for staff support, if at all possible (Dr Franklin Baer interview). Project AXXes in E Congo between 2006 - 2010 demonstrates that effective developmental health services are possible during insecurity and conflict. Several practitioners suggested the need for a more balanced funding system for transition periods in areas of conflict and emergency.

phase may persist indefinitely.[23] We therefore recommend that donors, including DFID, fund longer term, centrally and peripherally focused health systems strengthening in fragile states. World Vision believes that funding through a more flexible and adaptable frameworks, would allow for funding mechanisms (such as large Multi-Donor Trust Funds and other large joint-donor initiatives) to combine the immediacy of humanitarian response with the longer term commitment needed for a systems strengthening approach. This would give the flexibility needed to both respond to immediate need as well as provide the funding to help with various critical aspects of health systems strengthening, especially service delivery, community empowerment, long-term health policy formation, the private sector and the removal of user fees.

Programming in fragile states is riskier than in more stable contexts and the decision to provide shorter term funding is often taken in order to afford a greater degree of control for donors. This approach leads to state avoidance and short-termism, which does not address the serious issues of state weakness, gender disempowerment and the accountability deficit.

[23] World Bank, World Development Report 2010

Above: A mother and child in Kenya, visiting a health clinic set up as part of the response to the Horn of Africa Drought.
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At the high level, it should be noted that DFID have committed to bilateral funding levels for all countries until 2015 and they have developed long-term partnerships in fragile states with other donors in order to support joint funding mechanisms. However, when the funding gets to the level of an implementing partner, for instance donor funding cycles to NGOs in fragile states are often between 6 and 18 months.[24] As, among other issues, procurement and human resources, are harder and more expensive in fragile states, projects running with short-term funding cycles are consequently incentivised to focus on short-term indicators and are not incentivised to invest in long-term systems strengthening, capacity building or community accountability.

World Vision have demonstrated the way in which health systems can be strengthened in fragile states, but long-term funding is critical to this effort.[25] For instance, to effectively improve MNCH outcomes will require a continuum of care approach with regards to time (from pre-pregnancy to childhood) and location (from national through to community and as with all development focused on **community system strengthening**, a long-term and consistent approach is essential.

Community system strengthening, especially where health systems are weak, should not be seen as an add-on, but a fundamental aspect of development in fragile states. Background research for this paper showed

[24] DFID has referenced the negative impact of short-term funding cycles, but this must now be accompanied by real change. This is particularly difficult when support to many fragile states is still termed humanitarian and often pooled – meaning that the funds are managed by the UN or World Bank: Nick Chapman and Charlotte Vaillant, Synthesis of Country Programme Evaluations Conducted in Fragile States, (DFID, 2010): http://www.dfid.gov.uk/Documents/publications1/evaluation/syn-cnty-prog-evals-frag-sts.pdf
[25] ter Veen & Commins, *From Services to Systems*

that development actors, including national governments, NGOs and donors, must support communities in mobilising and taking the lead in demanding and ensuring consistent provision of essential care for mothers and their children from pre-pregnancy, during and after birth and through to the age of 5. Whilst this is key in all development programmes and not specific to fragile states, communities' cohesion is weaker in these contexts and as such must be proactively encouraged.

EXAMPLES

SOUTH SUDAN: With the transitional government set up in the wake of the Comprehensive Peace Agreement, the post-conflict processes had serious problems. Turnover - government officials were replaced, international humanitarian actors left the country to be substituted by new colleagues – led to slow national policy and strategy development. In addition, new appeals were launched and aid instruments established in response to delays of donor disbursements against the pledges made at the donor conferences for the two countries. The Multi Donor Trust Fund (MDTF), originally included in the donor agreements, was created for the implementation of the reconstruction programme. However, since aid used also parallel traditional instruments and channels and the establishment and functioning of the MDTF took a long time, links between the humanitarian and recovery activities were weakened. This complex bureaucracy and procrastination by donors left the population of southern Sudan bereft of basic services.

LIBERIA: advocacy by the country staff of the donor agencies themselves, supported by NGOs, resulted in a rare victory for long-term funding during the transitional period and a much more successful transition to development aid. Nevertheless, the Liberian Ministry of Health still has difficulties gaining donor commitment for more than one or two years at a time, as reported by the Minister, Walter Gwenigale in June 2011.

Alongside the low levels of donor funding directed through governments, **inadequate government health budgets** are a significant reason why the role of fragile state governments is limited to policy development and not service delivery. Despite pledging to allocate 15% of their budget to health[26], currently only 9% of the DRC government budget is allocated to health with, according to the National Health Account 2008-2009, "few resources (8% of its health spending) [allocated] to the operational costs of health services including the supply of inputs to health facilities".[27] This undermines the Ministry of Health's capacity to deliver including to manage and mobilise a centralised pharmacy and health supply depot and logistics to effectively deliver the needed resources to health zones and centres. The engagement of NGOs, Private Sector, Bilateral Donors and Civil Society Organisations, help cover some of those areas not covered by government. However, there remains a huge gap.

In Pakistan, the Government have attempted to bridge the gap through better **public-private partnerships.** Pakistan has a flourishing network of

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[26] Abuja Declaration: http://www.un.org/en/africarenewal/vol15no1/151aids5.htm (Accessed 9 November 2012)

[27] USAID, DRC *National Health Accounts 2008-9*, (USAID, 2010): http://www.who.int/nha/country/cod/drc_nha_2008-2009-eng.pdf

Above: A doctor in Sindh, Pakistan, gives medicines to a woman at a Primary Health Centre.
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private health care providers with a large number of users. For instance, 49% of diarrhoea cases initially seek care from private practitioners. Recent data indicates that a majority of women in urban areas, and a significant proportion of them in the semi-urban areas use private sector facilities for prenatal and postnatal care, delivery, newborn care and family planning. The government spends 4% of its budget on health, only 1% of the country's GDP.[28] More than 45% of this budget is consumed by curative services, mostly at tertiary hospitals. As a result, the role of the private sector is critical, as has been shown in family planning service provision. This led to a novel initiative to strengthen the emergency medical & obstetric services in Islamabad involving the public and the private sector.

Nevertheless, whilst private sector involvement may be important, a key concern for health access in fragile states is the charging of **user fees** which leads to unsustainable levels of expenditure by the poor on services of often poor quality, pushing many deeper into poverty.[29] There is a clear conflict between the support/acceptance of a health system policy framework that is anchored in a fee-charging health service delivery model and a widespread corruption culture that is inadvertently fuelled by the financial transaction of receiving health services from public sector providers.[30] Fee charging contributes to increased levels of poverty, creates leverage for corrupt individuals and organisations and reduces the effectiveness of government health policy.

[28] WHO, *Global Health Expenditure Atlas*, (WHO, 2012)
[29] WHO, *World Health Report 2010*, (WHO, 2010)
[30] WHO, *World Health Report 2010*

In DRC, 36% of all funding on health comes from household budgets[31] and, according to the latest WHO National Health Accounts in 2008-2009, in child health this rose to 46%, with the government providing only 0.3% of expenditure on child health.[32] With 70% of the population living on less than a dollar a day, this is an unsustainable situation.[33] As demonstrated clearly in the World Health Report 2010, the impact of direct user fees is catastrophic on health outcomes, and globally pushes 100 million people below the poverty line every year.[34]

IRC have demonstrated that the targeted abolition of user fees in fragile states can have a dramatic impact on mothers and children accessing healthcare – they were able to more than double the number of consultations per person from 0.37 to 0.7 within two months in three health zones in Province Oriental, in DRC. This remained constant for over a year and in 2012 stabilised at an utilisation rate of 0.82.[35]

The removal of user fees is clearly an important step in removing access barriers to healthcare. The evidence is substantial and convincing that this should be a priority in all contexts, not least fragile ones, where ability to pay and health outcomes are among the lowest in the world. This is by no means simple; the removal of user fees needs to be done carefully and in a way that is context specific.[36] In fragile states, such as Pakistan, where many of the health providers are private this is particularly difficult.

The recent 2012 Lancet Series on Universal Health Coverage (UHC) highlights that although there are many different paths towards UHC, political will and an effective form of financial risk sharing is universally necessary.[37] Much work needs to be done on how this agenda can be furthered in fragile states, but the Lancet Series rejects the notion that UHC is not applicable in certain contexts. However consensus forms on UHC in fragile states, it will need both political will and international cooperation for it to be realised. For instance, if it is the private sector providing services, removal of fees is not feasible unless there are effective, risk sharing and equitable sources of financing to ensure continuation of services. This makes long-term and predictable support from donors critical.

DFID should look to reorient its approach to MNCH in fragile states away from the largely humanitarian approach towards development. In reality this will look like a much stronger focus on systems building and much longer funding cycles, which prioritise issues such as community resilience and gender empowerment in addition to the prevailing focus on service delivery.
World Vision recommends that:

- In addition to humanitarian support in times of crises, DFID funding and strategies for MNCH programmes in fragile states should be medium to long-term in nature, attaining funding intent similar to Liberia;

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[31] WHO, *Global Health Expenditure Atlas*
[32] USAID, DRC National Health Accounts 2008-9
[33] The National 1-2-3 survey in 2004-2005, says that 71.3% of Congolese live under the national poverty line. In rural areas, this figure is 75.7% and in urban areas 61.5%
[34] WHO, *World Health Report 2010*
[35] IRC, *Access to Health Care & User Fees: Experience with Fully Subsidized Health Care for Targeted Groups in the Democratic Republic of Congo*, (IRC, 2012)
[36] Action for Global Health, *Your Money or Your Life: Will leaders act now to save lives and make health care free in poor countries?*, (Oxfam International, 2009)
[37] "Universal Health Coverage Themed issue", *The Lancet*, (Vol. 380, 2012)

- in bilateral funding to fragile states, DFID should ensure that all successful grant proposals include government capacity building at the state, regional and local level;
- DFID should work with joint donor funding mechanisms to ensure that implementing agencies have longer term funding cycles;
- DFID in the UK and in Country offices should champion health systems strengthening in fragile states; and
- DFID should explore how its health sector development programmes in fragile states can include a mechanism for supporting the strengthening domestic accountability and citizen voice, similar to the DFID 5% commitment to supporting domestic accountability in budget support countries[38].

Above: A child with her mother in Afghanistan at a women's health centre. Women can visit the centre to receive voluntary and confident counselling and support services. On average there are 20 women a day who come to this health centre and 70% come to access family planning services. © 2012 Paul Bettings/ World Vision

[38] DFID, *Strengthening Accountability in Budget Support Countries - DFID's 5% Commitment: Briefing Note for Country Offices*, (DFID): http://www.dfid.gov.uk/Documents/publications1/5-percent-Briefing-Note-apr11.pdf

Recommendation 3: Global Health Partnerships should develop specific fragile state policies or strategies in order to ensure an integrated approach to health systems strengthening in fragile states.

In 2010, a number of senior advisers at the Global Fund published an article in the Global Health Governance Journal about the Global Fund's Experience of Health Aid Governance in Fragile States.[39] At the time of publication, the Global Fund had disbursed $5bn in fragile states, representing 40% of Global Fund projects. They had evaluated a number of the Global Fund's projects in fragile states and concluded that, where conflict was present, they generally performed far worse than projects in more stable environments. They concluded that the Global Fund should have a greater focus on more rapid disbursement of funding and "building capacity and strengthening the governance of health systems in these countries."[40]

Global Health Parternships (GHPs, often referred to as "vertical funds"), such as the Global Fund to fight Aids, Tuberculosis and Malaria (the Global Fund), have a real challenge to better support long-term, systems focused investment in fragile states. They are able to invest significant resources into achieving specific outcomes and have achieved impressive results. However, due to the large sums and the specificity of their inputs, there should be more awareness of their ability to circumvent and skew health systems. Health systems follow the money and when GHPs invest significantly in vertical interventions it can lead to an imbalanced health system, designed around the implementation of specific interventions and not holistic healthcare which in turn leaves out vulnerable people in need (see box)

The "New Deal for Fragile States" calls for donors to "commit to build mutual trust by providing aid and managing resources more effectively and aligning these resources for results."[41] Within this is the commitment to use, strengthen and support country led plans and systems. However, GHPs have shied away from developing specific policies for work in fragile states. The level of investment they bring, the focus they are able to give to specific outcomes and the results that they are able to achieve can be beneficial. However, many GHPs need to be much more serious about aligning behind long-term development objectives. They need to be much more responsive to local priorities and demands and, especially in fragile states they need to be much more intentional about building state society relations.[42]

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[39] Olga Bornemisza, et al, "Health Aid Governance in Fragile States: The Global Fund Experience", *Global Health Governance Journal*, (Vol 4, 2010)
[40] Bornemisza, et al, *Health Aid Governance in Fragile States*
[41] *A New Deal for Engagement in Fragile States*, http://www.oecd.org/international%20 dialogue/49151944.pdf
[42] Bornemisza, et al, *Health Aid Governance in Fragile States*

a. "International partners have done a lot of work to meet humanitarian need and coordinated well with us but for regular programs, they have never approached us for issues and what problems we have in coordination. I don't believe in setting up vertical programs, and there should be support to strengthening systems instead of setting up new structures. We will refuse such things from now" **Public Sector Health Worker, Khyberpakhtoonkuk Province, Pakistan**

b. "I have 50 malnourished children, but only the 10 who have been affected by HIV/AIDs are eligible for the support from the Global Fund. When a child is malnourished he is malnourished. The Global Fund helps with some, but I have responsibility for them all and feel undermined" **Health Zone Manager, Katanga Province, DRC**

DFID is a major funder, and political supporter, of key GHPs funds, such as GAVI and the Global Fund. DFID should therefore work (either through the Multilateral Aid Review process or through continued day-to-day engagement) with GHPs to develop specific policies for their work in fragile states that:

- carries out regular assessments to understand the contexts and the specific challenges in greater detail;
- ensures alignment with donor funding and government development plans (at the national, regional and local level);
- aligns with local priorities and build on existing initiatives where possible, rather than imposing new ones;
- invests in the building blocks of health systems, as defined by the WHO[43], from the local to the national level;
- has a particular focus and designated funds to invest in citizen accountability mechanisms; and
- includes a far greater emphasis on gender empowerment in services.

Recommendation 4: NGOs should use their capacity and expertise to strengthen regional and local government systems and policies

NGOs, whether International NGOs such as World Vision, small local civil society groups or churches, can play an important role in building and catalysing government capacity to deliver services. These NGOs have different strengths, but they have often built up considerable experience in service delivery in conflict and post-conflict contexts, and this is a strength that they can contribute to the post-conflict recovery process. For instance, the Catholic diocese and Protestant churches have been very active in providing social services in DRC since the early 1900's and the health systems in the DRC

[43] Leadership and Governance, Financing, Human Resources, Health Information, Medical and Drug Supply Systems and Service Delivery: WHO, *Health Systems*: http://www.who.int/healthsystems/en/ (Accessed 9 November 2012)

have been established over a number of decades based on the experience of mostly church based hospitals and rural health centres. Similarly, NGOs, such as World Vision, provide approximately 80% of health services in South Sudan.[44]

NGO staff are often keenly aware of local population health needs, and the strengths and pitfalls of service delivery as they are often present before, during and after a crisis. At the same time, their scope of activity can be more limited in terms of addressing root causes of poor maternal and child health, such as poverty, low levels of education, and gender disparities and rights, or access issues such as a lack of qualified health workers. In addition, various stakeholders have faced challenges with a lack of reliable data to help inform programme and policy priorities due to weak health information systems.

In South Sudan, World Vision has been supporting health systems in Warrap state since 1983. Due to the 20 year civil war which ended in 2005 and, since then, the ongoing violence along the border the people in this state have suffered greatly from continued conflict, disruption and displacement. Since peace and independence the government and NGOs have worked to build infrastructure and strengthen health systems. However there is a lot of work to accomplish if children are to access the health services they need. Health facilities are unlikely to have any highly trained medical staff (doctors/nurses) and there is only 1 nutritionist for the entire state. Because of flooding and poor infrastructure, getting from place to place is often impossible by motor vehicle. The health system is not able adequately to support the supplies and staff necessary to roll out essential programmes such as efforts to address acute malnutrition or provide immunizations. Because of variability in seasonal rains, there is often drought or flooding which impedes families' access to nutritious food all year round.

To fill this gap, World Vision has been working with the State Ministry of Health, the UN and donor governments to fill these gaps and strengthen the system simultaneously. This includes training and salary support for Ministry of Health staff, mobilising community health workers to provide basic linkage and referrals, and supporting logistic and supply needs for primary and secondary health centres. This support is channelled as much as possible through state ministries so that as they gain capacity, World Vision can hand over activities. Beyond this, World Vision supports activities in a wide range of sectors including water, sanitation, peace building, child protection, education and food security.

As a rule of thumb, the more fragile the context the more relied upon non-state actors (whether NGOs of the private sector) are to deliver MNCH services. They therefore have a crucial role to play in developing government capacity. World Vision's experience tells us that NGOs should:

- invest in, maintain and act on context analyses;
- invest in collective support structures for the leadership in fragile context country offices or partners;
- develop better models to provide core funding, general resourcing and efficient models to manage the cost base; and

[44] Sebastian Taylor, *Beyond the Health Governance Gap: Maternal, newborn and child health in South Sudan,* (World Vision, 2012)

- improve HR practices, be more security conscious, increase stability of contracts, normalise careers and invest in support for staff. This will increase retention, reduce stress and ensure staff are able to have a long-term perspective.

NGOs have a significant opportunity to support the development of regional and local health systems and should prioritise this as part of their development and theories of change; they should look to integrate as much as possible with government led processes, and should work to build capacity within local authorities. Examples of how this has been done successfully include:

- making available senior staff time to contribute to the policy-making and institution-building processes. They can contribute their local insight and experience, a focus on drivers of MNCH, institutional knowledge to guide policy and planning processes and ensure that crucial issues such as human resources planning and the need to address health through a multi-sectoral approach are not overlooked;
- integrating knowledge gained through the policy processes to adapt service delivery to national standards, and training all supervisory and health facility staff accordingly; and
- establishing community mechanisms to support service delivery, that can in a later phase directly deal with the public health sector in the form of advocacy and accountability once stronger government systems are in place; and
- contribute to strengthening information management systems.

Below: A refugee child from DRC suffering from acute undernutrition being treated at a health centre in Rwanda. © 2012 Kari Costanza/World Vision

Bibliography

- Abuja Declaration: http://www.un.org/en/africarenewal/vol15no1/151aids5.htm (Accessed 9 November 2012)
- Action for Global Health, *Your Money or Your Life: Will leaders act now to save lives and make health care free in poor countries?*, (Oxfam International, 2009) "Universal Health Coverage Themed issue", *The Lancet*, (Vol. 380, 2012)
- Olga Bornemisza, et al, "Health Aid Governance in Fragile States: The Global Fund Experience", *Global Health Governance Journal*, (Vol 4, 2010)
- Nick Chapman and Charlotte Vaillant, *Synthesis of Country Programme Evaluations Conducted in Fragile States*, (DFID, 2010): http://www.dfid.gov.uk/Documents/publications1/evaluation/syn-cnty-prog-evals-frag-sts.pdf
- DFID, *What We Do: Governance and Conflict*: http://www.dfid.gov.uk/What-we-do/Key-Issues/Governance-and-conflict/ (Accessed 9 November 2012)
- DFID project database: http://projects.dfid.gov.uk/project.aspx?Project=202732(Accessed 9 November 2012)
- DFID, *Strengthening Accountability in Budget Support Countries - DFID's 5% Commitment: Briefing Note for Country Offices*, (DFID): http://www.dfid.gov.uk/Documents/publications1/5-percent-Briefing-Note-apr11.pdf
- Department of Education, *Introduction to the Pupil Premium*: http://www.education.gov.uk/schools/pupilsupport/premium/b0076063/pp (Accessed 9 November 2012)
- Debarati Guha-Sapir and Olivia D'Aoust *World Development Report 2011: Background paper on demographic and health consequences of civil conflict*, (World Bank, 2010).
- Degomme, O. and Guha-Sapir, "Patterns of mortality rates in Darfur conflict", *The Lancet*, (Vol. 375, 2010)
- HMG, *Building Stability Overseas Strategy*, (HMG, 2011)
- Hoeffler, Anke, and Martha Reynal-Querol. *Measuring the Cost of Conflict*, (Oxford University 2003)
- Margaret C Hogan et al., "Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5", *The Lancet*, (Vol. 375, 2010)
- IRC, *Mortality in the Democratic Republic of the Congo: an ongoing crisis*, (IRC, 2007)
- IRC, *Access to Health Care & User Fees: Experience with Fully Subsidized Health Care for Targeted Groups in the Democratic Republic of Congo*, (IRC, 2012)
- *A New Deal for Engagement in Fragile States*, http://www.oecd.org/international%20dialogue/49151944.pdf
- David Nabarro, *The ultimate challenge: sustaining life in fragile states*, presentation given at the High level forum, Abuja, (2004)
- Oxfam, *Evidence to IDC on Fragile States*: http://www.publications.parliament.uk/pa/cm201012/cmselect/cmintdev/1570/1570vw10.htm
- Javier Pereira and Carlos Villota, *Hitting the target? Evaluating the effectiveness of results-based approaches to aid*, (Eurodad 2012)
- Sebastian Taylor, *Beyond the Health Governance Gap: Maternal, newborn and child health in South Sudan*, (World Vision, 2012)

- USAID and Basics, *Fragile States*: http://www.basics.org/reports/FinalReport/Fragile-States-Final-Report_BASICS.pdf (Accessed 9 November 2012)
- USAID, *DRC National Health Accounts 2008-9*, (USAID, 2010): http://www.who.int/nha/country/cod/drc_nha_2008-2009-eng.pdf
- Annemarie ter Veen and Stephen Commins, *From Services to Systems: Entry points for donors and nonstate partners seeking to strengthen health systems in fragile states*, (World Vision Canada, 2011)
- WHO, *Global Health Expenditure Atlas*, (WHO, 2012)
- WHO, *World Health Report 2010*, (WHO, 2010)
- WHO, *Health Systems*: http://www.who.int/healthsystems/en/ (Accessed 9 November 2012)
- World Bank, *World Development Report 2010*, (World Bank, 2011)
- World Vision, *Child Health Now: Together we can end preventable deaths*, (World Vision, 2009)

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