

HEALTH FINANCING IN FRAGILE AND CONFLICT-AFFECTED SITUATIONS: A REVIEW OF THE EVIDENCE



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World Health
Organization

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TABLE OF CONTENTS

- Acknowledgements vi**
- Acronyms vi**
- Executive summary viii**
- Background..... 1**

- Implications for health financing..... 4**
 - Revenue raising and pooling5
 - Government expenditure5
 - External finance6
 - Out of pocket payments9
 - Overall expenditure and pooling.....11
 - Sub-group and trend analysis in revenue collection and pooling 12
 - Purchasing 13
 - Assessing needs and performance..... 13
 - Provider payments..... 13
 - Monitoring payment and outcomes 14
 - Benefits packages 14
 - Entitlements 14
 - Provision 15
 - UHC objectives 15
 - Resource allocation 15
 - Technical efficiency 16
 - Allocative efficiency 17
 - Governance 17
 - UHC goals 17
 - Equitable access 17
 - Financial protection 20
 - Cross-cutting issues 23
 - Public financial management 23
 - Opportunities for reform 24
 - Resilience 25

- Policy responses 26**
 - Revenue raising and pooling 26
 - Improving flow and use of external finance..... 26
 - Contributory mechanisms 27
 - User fee exemptions or targeted exemptions for vulnerable groups 28
 - Health equity funds 29
 - Demand-side financing 30
 - Health financing in emergency settings 33
 - Purchasing 35
 - Contracting of services..... 36
 - Performance-based financing (PBF)..... 38
 - Accreditation and regulation of providers..... 39
 - Benefits packages 40
 - Service delivery during emergencies..... 42

Effective engagement in health financing and health systems assistance.....	43
Gaps in knowledge.....	47
Conclusion and final reflections.....	49
References	52
Annex 1: Approach to developing this paper.....	71
Review of the literature.....	71
Quantitative analysis.....	73
Annex 2: Defining fragility.....	76
Definitions and drivers	76
Typologies.....	78
Annex 3: FCAS countries list	82
Annex 4: Trend analysis	84

LIST OF TABLES

Table 1: Summary of common health financing challenges, responses and gaps in FCAS settings.....	ix
Table 3: Summary of results of quantitative analysis: Proportion of domestic general government health expenditures as a % of current health expenditures, FCAS vs. non-FCAS countries, 2012-2014	7
Table 4: Summary of results of quantitative analysis: Proportion of external funding as a % of current health expenditures, FCAS vs. non-FCAS countries, 2012-2014.....	8
Table 5: Summary of results of quantitative analysis: Proportion of out of pocket payments as % of current health expenditure, FCAS vs. non-FCAS countries, 2012-2014	10
Table 6: Summary of results of quantitative analysis: total health expenditures as a % of GDP, FCAS vs. non-FCAS countries, 2012-2014	11
Table 7: Summary of results of quantitative analysis: UHC coverage index (%), FCAS vs. non-FCAS countries, 2015	19
Table 8: Summary of results on catastrophic expenditures (population with household expenditures on health greater than 10% of total household expenditure or income), FCAS vs. non-FCAS countries, dates vary.....	21
Table 9: Summary of results on catastrophic expenditures (population with household expenditures on health greater than 25% of total household expenditure or income), FCAS vs. non-FCAS countries, dates vary.....	21
Table 10: Summary of results on impoverishing expenditures (Population pushed below the \$1.90 a day poverty line by household health expenditures), FCAS vs. non-FCAS countries, dates vary	22
Table 11: Summary of results on impoverishing expenditures (Population pushed below the \$3.10 a day poverty line by household health expenditures), FCAS vs. non-FCAS countries, dates vary	23
Table 12: Main elements of the data extraction matrix.....	73
Table 13: Predefined codes for “main element of health financing” and “theme”	74
Table 14: Summary of outcomes considered and year(s) of reference.....	75
Table 15: FCAS countries.....	82

LIST OF FIGURES

Figure 1: UHC goals and intermediate objectives influenced by health financing policy.....4

Figure 2: Proportion of general government expenditure devoted to health, FCAS countries, 2012-2014.....6

Figure 3: Out of pocket payments (% of current health expenditure), FCAS countries, 2012-20149

Figure 4: UHC coverage index (2015), FCAS countries, 2015 18

Figure 5: Catastrophic payments, FCAS countries (most recent data points; dates vary)..... 20

Figure 6: Population impoverished by health expenditure, FCAS countries (most recent data points; dates vary).....22

Figure 7: Adaptations of PBF in three humanitarian settings, their drivers and facilitators 38

Figure 8: Studies identified on fragility and health.....76

Figure 9: Intersecting gaps of statehood79

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ACRONYMS

Acronyms	AFR(O)	African Region of the WHO
	BPHS	Basic Package of Health Services
	CAR	Central African Republic
	CBHI	Community Based Health Insurance
	CCT	Conditional Cash Transfer
	COEs	Challenging Operating Environments
	DFID	UK's Department for International Development
	DHM	District Health Management
	DRC	Democratic Republic of the Congo
	ECHO	European Civil Protection and Humanitarian Aid Operations
	EMR(O)	Eastern Mediterranean Region of the WHO
	EPHS	Essential Package of Health Services
	EPI	Expanded Programme of Immunization
	EU	European Union
	EUR(O)	European Region of the WHO
	FCAS	Fragile and Conflict-Affected Settings
	GAVI	Global Alliance for Vaccines and Immunization
	GCMU	Grants and Contracts Management Unit (Afghanistan)
	GDP	Gross Domestic Product
	GFATM	Global Fund for the fight of AIDS, Tuberculosis and Malaria
	GHI	Global Health Initiative
	HEFD	Health Economics and Financing Directorate (Afghanistan)
	HISE	Health Insurance Scheme (Iran)
	HRH	Human Resources for Health
	IASC	Inter-Agency Standing Committee
	IDA	International Development Association
	IDPs	Internally Displaced Populations
	LIC / L	Low Income Country
	LM	Lower Middle Income Country

LICUS	Lower Income Countries Under Stress
LMIC	Low and Middle Income Countries
MCH	Maternal and Child Health
MDTF	Multi Donor Trust Fund
MIC	Middle Income Country
Mo(P)H	Ministry of Health / Ministry of Public Health
MSF	Medecins sans Frontieres
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHI	National Health Insurance
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
P4P	Pay for Performance
PBF	Performance Based Financing
PFM	Public Finance Management
PHC	Primary Health Care
RBF	Results Based Financing
RH	Reproductive Health
SDGs	Sustainable Development Goals
SEAR	South-East Asia region of the WHO
SOAs	Special Operating Agencies
SWAp	Sector Wide Approach
UHC	Universal Health Coverage
UM	Upper Middle Income Country
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization
WPR	Western Pacific Region of the WHO

EXECUTIVE SUMMARY

WHO has well-developed guidance for the development of health financing policy, which supports progress towards universal health coverage (UHC) and overall health system goals. Most recently, a series of health financing guiding principles have been proposed, based around the different functions of health financing policy (Kutzin et al., 2017; McIntyre and Kutzin, 2016). The key messages in these guidance documents centre heavily on the importance of public finances, and the role of government in using those finances in the best way to strengthen their health system and maximise progress towards UHC.

Fragile and conflict affected states (FCAS) present a growing challenge for achieving UHC and other developmental goals. In this paper, we examine core features of FCAS settings, which centre on deficits in capacity, legitimacy and security, and what this implies for health systems, but more specifically for health financing and in relation to the key messages and policy guidance currently offered by WHO. We explore common health financing constraints and opportunities and how policies have responded to these. These are summarised in Table 1.

Our data analysis has shown that, as would be expected, FCAS countries have significantly higher out of pocket expenditure, external dependency and health-related impoverishment. They also have lower mean government expenditure on health in relation to wider government expenditure and total health expenditure. However, much of this is driven by the tendency of FCAS to be low

income; when stratified, there are fewer clear differences at low income levels, whereas external dependence and impoverishment remain significantly higher for upper-middle income FCAS, perhaps indicating the effects of shocks.

Conflict-affected countries within the FCAS grouping show similar patterns but more accentuated, with less external support and lower overall expenditure on health. Chronic FCAS countries (those in this category for more than five years) showed similar patterns to the wider group.

Trends analysis shows some improvement in FCAS performance on health financing indicators over recent years, but from generally lower starting points and with regional variations. In terms of UHC coverage, FCAS have lower performance for all income levels.

There are substantial challenges for health financing in FCAS settings but considerable ingenuity has also been shown in addressing them, albeit often externally driven. It is also important to highlight that many models have been developed and road-tested in FCAS settings – approaches such as performance-based contracting and PBF emerged to a large extent out of the need to innovate in FCAS and have since been applied in wider contexts. The literature highlights that crises often lead to innovation, and that innovations can leave a longer legacy (the issue of path dependency), which reinforces the need to use crises well.

Table 1: Summary of common health financing challenges, responses and gaps in FCAS settings

Health financing function	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)
<p>Revenue raising and pooling</p> <p><i>Aims:</i> Increase flows from public and mandatory sources</p> <p>Increase predictability and stability of funds</p> <p>Enhance redistribution of prepaid funds</p> <p>Ensure that funding sources are complementary</p> <p>Reduce fragmentation, duplication and overlaps</p> <p>Simplify financial flows</p>	<ul style="list-style-type: none"> - Public funding is often low (low GDP growth; low taxation; non-prioritisation of social sectors) - May be multiple authorities collecting revenues - Limited territorial control reduces government revenue base - Conflict additionally tends to depress health expenditure (2%/year, according to one study), while raising needs (disrupted services, displaced populations etc.) - High dependence on external funding (donors, charities, remittances). Problems relating to this include instability; lack of predictability; and lack of alignment with public priorities (e.g. high volumes off-budget and off-plan) - External support is very varied by country; relative to stable countries, donors preferred to provide more funding to low-income fragile countries that have refugees or on-going external intervention but tended to avoid providing funding to countries with political gridlock, flawed elections, or economic decline. - FCAS associated with higher external finance for MICs, not LICs (compared to non-FCAS LMICs) - External finance can be too low for needs, while also being high relative to absorptive capacity (especially if there is a post-crisis funding influx), leading to low disbursement - High levels of out of pocket payments, in contexts where household incomes are often low and subject to shocks, with high levels of health need - Low overall funding, though can in cases be high but poorly distributed - Low trust undermines pooling – leads to lower levels of prepayment; more fragmented risk pools - Segmented population, especially where there are substantial refugee and displaced populations having varying protection 	<ul style="list-style-type: none"> - Aid pooling and coordination mechanisms, including shadow alignment - Policies to increase financial access and decrease out of pocket payments, including: user fee exemptions, health equity funds, health insurance, demand side financing - Greater use of cash, card-based and mobile payments in humanitarian settings <p><i>Gaps:</i></p> <ul style="list-style-type: none"> - more attention could be paid to ensuring stable, predictable revenues, including use of revenue from extractives and sin taxes, as well as remittances, but challenge is to increase tax equitably - how to harmonise/integrate different strategies to increase access, including across humanitarian and development programmes, and during transitions between them - Assumption of decreasing financial dependency post-shock not well studied; dependency is also more than just financial
<p>Purchasing</p> <p><i>Aims:</i> Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination</p> <p>Move away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement</p> <p>Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements</p> <p>Move towards a unified data platform on patient activity, even if there are multiple health financing / health coverage schemes</p>	<ul style="list-style-type: none"> - Multiple (uncoordinated and unaligned) purchasers (with households often dominant) - Data on and assessment of population needs and provider performance is limited and often fragmented - Fee for service payment dominates in private, informal sectors; public sector commonly a mix of fixed (under-funded) budgets and user fees; various forms of contracting in humanitarian sector - Where there is lack of confidence in government by donors, funding is often channelled to (I) NGOs, leading to patchy provision and often higher costs (inefficient provision) - Data on payments and outcomes not unified or linked - Complex remuneration and weak regulation undermines accountability of providers 	<ul style="list-style-type: none"> - Contracting and performance-based contracting, often with NGOs - Performance-based financing in both fragile but relatively stable as well as humanitarian contexts. <p><i>Gaps:</i></p> <ul style="list-style-type: none"> - Overall purchasing assessments and how to defragment it and improve its performance, also working across humanitarian and development silos - Development of context-specific regulatory models for different sectors

Table 1: Contd.

Health financing function	Summary of common challenges in FCAS settings	Strategies adopted to mitigate these (and gaps)
<p>Benefits packages</p> <p><i>Aims:</i></p> <p>Clarify the population's legal entitlements and obligations</p> <p>Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries</p> <p>Align promised benefits, or entitlements, with provider payment mechanisms</p>	<ul style="list-style-type: none"> - Entitlements often unclear and not linked to funding - Population awareness of entitlements is low - Well defined health care packages are often missing, meaning care seeking can be irrational - Fragmented funding influences service provision <ul style="list-style-type: none"> - e.g. vertical programmes can give resourcing preference to some disease areas - Service provision capacity may be disrupted, with patchy coverage and low quality of care - Parallel provision for refugees in many settings and challenges transitioning away from this 	<ul style="list-style-type: none"> - Development and implementation of essential health care packages <p><i>Gaps:</i></p> <ul style="list-style-type: none"> - More work is needed on quality of care in FCAS settings - Dynamic costing of packages to allow for changing contexts - Greater integration of humanitarian purchasing and provision
UHC objectives	<ul style="list-style-type: none"> - Resources captured; not flowing to populations with highest need - Gaps in critical resources can make even limited resource inefficient (e.g. public budgets often focussed on salaries, leaving lack of funds for drugs, outreach, supplies, supervision, especially for frontline PHC services) - Non-priority care can gain bulk of resources (e.g. prevention and lower cost, more equitable services neglected) - Governance and reporting weak: limited transparency and accountability, often exacerbated by external dependence 	
UHC goals	<ul style="list-style-type: none"> - Financial and non-financial barriers: inequitable access - Underconsumption of care by poor and marginalised, exacerbated by physical access barriers, especially with shifting populations & in slum areas - Catastrophic payments, especially for chronic illness - Regressive financing of health care, especially when out of pocket payments predominate - Quality of care often poorly regulated and can be low 	
Other cross-cutting	<ul style="list-style-type: none"> - Weak public financial management systems contribute to many of the challenges above, and are also themselves undermined by plethora of aid funding channels - Health financing institutions have low capacity, which is hard to build in a context of chronic or intermittent shocks - Conflict and institutional weakness can block systemic reforms, although there is also some evidence for windows of opportunity opening post-crisis (in some circumstances) 	

In drawing conclusions, it is important to highlight the heterogeneity of FCAS settings and the need to focus on each context as unique, with its particular challenges, opportunities and history. While there are some shared features, our analysis of overall datasets demonstrates the variation in performance on most health financing indicators, and also that many FCAS countries share features with low income countries generally.

Given this, the guiding principles for health financing reforms in support of universal

health coverage (Kutzin et al., 2017) still apply in FCAS settings – in fact, even more so, given the greater severity of the challenges that they often face, such as fragmentation, complexity and volatility of funds, for example. However, their operationalization may need to be different and achieving them may take a longer or more staged journey – for example, moving from unregulated fees for service to flat fees (i.e. a fixed amount for the entirety of a health service provided, rather than an itemized bill/payment), to increase predictability of payments, before gradually shifting more systematically away

from out of pocket payments for core health services. Similarly, in some settings donors may be unable to work through government but can move toward better coordination with government to avoid fragmentation and service gaps. Within Ministries, the development of project implementation units with semi-autonomy is arguably another such transitional mechanism, aiming to fill short term capacity gaps while offering a route to their longer term strengthening.

Given the regional nature of many conflicts and shocks, health financing analysis and support may be needed at regional level – for example in the EMRO region, where all countries are either directly or indirectly affected by conflict – as well as at national and sub-national levels. The focus should be on tailored strategies, which build on international learning but are closely contextualised and able to adapt. The only certainty is change, and building capacity to manage change is critical.

Although FCAS settings go through different phases, such as pre-crisis, reacting to crisis, stabilisation and recovery, many now face chronic problems and complex emergencies, in which strategies for humanitarian response and development converge. Lessons on contracting health care provision and insurance models are just some examples of areas where this convergence is occurring and can be further pursued. This is important to managing transitions.

Important messages emerging from this review include the following:

- All FCAS settings have health financing challenges but those which combine deficits in security, capacity and legitimacy are most extreme and require

support which is adaptable, long term and politically astute.

- Political economy considerations are important in all settings but FCAS often require particular sensitivity, given the underlying factors fuelling fragility, and typically include a larger role for external actors.
- Strategies in these areas need to be based on understanding the internal and external agency incentives, looking for politically feasible improvements, even where not optimal, and enabling work across politically contested areas.
- Many of the health financing challenges are linked to this configuration, with external actors adding to the fragmentation of policies and practices in many cases – hence the importance of coordination, even if direct relationships with governments are constrained.
- In some of these settings (e.g. acute crises or gradual collapse of functions), appropriate goals for health financing may be not so much advancing UHC but preventing loss of gains – for example, preventing a reversal of financial protection as budgets collapse and out of pocket payments replace them.
- Support needs to be tailored to regional, national and sub-national levels, including for specific vulnerable populations, such as refugees and other displaced people, who typically have higher health needs (such as mental health) and may have more limited entitlements and access.
- In chronic emergency settings where wider institutional structures exist,

humanitarian and development assistance should aim to pool risks (e.g. through local risk-sharing schemes e.g. a social health insurance) and provide service coverage (e.g. through purchasing contracts with relevant providers) through these structures as far as possible, investing in longer term institutional capacity and avoiding parallel systems. During acute crises, this may not be possible but even in these settings distortions can be minimised.

- Recognising the importance of stable funding flows, more advocacy is needed for continued, predictable and (where possible) integrated external funding, with external partners refocusing their aid and support on those in most need globally.
- Further pooling of donor support, including harmonizing financial management, human resource and other procedures across donors, implementing agencies and districts, including through shadow alignment where needed, is recommended.
- Given higher levels of resource scarcity in many FCAS settings, coupled with high need, there is an even higher need than usual to focus resources on priority services (focused on vulnerable populations, with cost-effective services). The development of essential service packages is common in FCAS settings and can form the basis for pooled funding by government and donors.
- In the context of underlying economic and social challenges, displacement and conflict and other crises, households' ability to access and pay for health care

is typically reduced in FCAS settings, and attention to reducing financial and non-financial barriers is key; reports of reintroduction of fees in response to dwindling external support are concerning as populations are already bearing too high a burden in terms of out-of-pocket payments.

- The consensus on removing user fees in humanitarian crises is important in this context, but there are risks of difficult transitions when areas or populations emerge from acute crises, leading to loss of financial protection, coverage and health. Policies to extend protection and smooth transitions are important.
- There is an increased focus on cash transfers in general in development, however in the health sector conditional cash transfers need to be combined with well-designed provider payments so that quality of care and appropriate care packages are offered (focused on those in need but also emphasising preventive health and public health measures). Unconditional cash transfers are more suited to addressing demand-side barriers, such as transport.
- Given the high likelihood of shocks, it is important to learn from the resilience literature on distributed capacity and plan health financing systems accordingly. Being better prepared for crisis may also include, for example, having basic packages established and costed, with draft contracts, so that governments and donors can react more quickly to shocks of various kinds; also having simple but functional systems for tracking expenditures and resource flows in the health system in place.

BACKGROUND

Fragility and conflict present a critical development challenge, affecting, eroding and hampering efforts to build healthy and prosperous societies. According to the World Bank (2018), two billion people now live in situations affected by fragility and conflict. The share of extreme poor living in conflict-affected situations is expected to rise from 17% of the global total today to almost 80% by 2030 if no action is taken (OECD, 2018). This is fuelled by growing inequality and the proliferation of acute and chronic conflicts, resulting in population displacement and systems breakdown, which spread risks across whole regions. Today's refugee population is the highest on record (UNHCR, 2017). More than 60% of maternal and child deaths occur in FCAS (OECD, 2018).

A recent study found that armed conflict substantially and persistently increases infant mortality in Africa, with effect sizes on a scale with malnutrition and several times greater than existing estimates of the mortality burden of conflict (Wagner et al., 2018). However, fragile states receive around 50% less aid than predicted, despite their high needs (Graves et al., 2015). In this context, making progress towards universal health coverage and meeting the Sustainable Development Goals (SDGs) is particularly challenging, but essential also in light of linkages with broader issues, such as state-building and stabilisation (Kruk et al., 2010a) and the global health security agenda (Ghebreyesus, 2018; Ooms, 2017).

Improving health financing systems is critical to enable countries to raise more resources

for health and make good choices about how to use them. However, the evidence of what works in these circumstances is limited. There is no clear guidance on how to translate and apply the existing lessons and principles on health financing for universal health coverage to fragile situations.

Against this backdrop, this paper¹ aims to highlight the health financing challenges specific to these contexts and refine existing thinking and advice on health financing policy, contributing to the development of more effective and contextualised health financing policy-making and technical support at national and regional levels.

IMPLICATIONS OF FCAS FOR THE HEALTH SECTOR

There is no single agreed definition of FCAS², but common elements across the definitions used include a focus on gaps in relation to three dimensions:

1. Government's **capacity and willingness to provide basic services** to its population (especially vulnerable groups).
2. Its **legitimacy**.
3. Its ability to provide **security and stability** (survival functions) (Witter et al., 2015).

1 **Annex 1** presents further information on how the paper was developed, including the experts' consultation and the methodological approach for the literature review and the data analysis components.

2 See **Annex 2** for a discussion on this, and **Annex 3** for the FCAS list used for the purposes of this document.

It is clear that settings where government institutions are incapable of or unwilling to provide basic services, legitimacy and security face particular set of challenges when it comes to health and health care systems (Witter and Hunter, 2017a).

NEED AND DEMAND

Fragility and crises are often accompanied by falls in employment, and the reduced ability of people to pay for health care is compounded by decreased government income and a drop in government spending on health (Witter and Hunter, 2017a). Conflict-affected settings in particular may experience the destruction of health facilities, disruption of systems processes, such as procurement and health information, and the emigration or deaths of health workers (Ager et al., 2105; Pavignani and Colombo, 2009). Any destruction or militarisation of transport infrastructure further exacerbates problems for ensuring geographical coverage of health services.

While coping with the loss of available resources, people in crisis-affected settings must also cope with rapidly changing burdens of disease. These include injuries and illnesses associated with violence, reduced food availability, resurgent infectious diseases, population movements, the mental health problems that accompany crises, as well as the burden of chronic disease that is growing worldwide (Spiegel et al., 2010). Governments are thus expected to do more with less, and it is health workers who bear the brunt of those pressures. These problems are compounded by reduced legitimacy of the state if the state is perceived by some societal groups to be ineffective or unresponsive (Whaites, 2008; Witter and Hunter, 2017b). This can further reduce state capacity to collect taxes and insurance contributions to fund the health system. Likewise crises may undermine social

cohesion and lead to exclusion of particular social groups from the health system based on their ethnicity or religion (Pearson, 2010).

SUPPLY

In fragile states, the health system building blocks are by definition weak and incomplete (Eldon et al., 2008). Characteristics include (Newbrander et al., 2011)

- inability to provide health services to a large proportion of the population outside urban areas;
- ineffective or non-existent 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;
- non-existent 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;
- lack of equity in who receives the available health services: few public health services exist for the poor and in rural areas;
- 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.

A growing body of work on the impact of conflict and crisis on the health workforce exists (Witter and Hunter, 2017c), highlighting the gaps, distortions and fragmentation of policies which typify FCAS settings, and draws out lessons for short and longer term HRH policies (Witter et al., 2016a).

A higher degree of aid dependence and complexity of aid partnerships are also typical features of FCAS settings, raising risks and opportunities for external actors which are summarised in Box 1.

Experimentation and innovation are encouraged by stressors. The ensuing achievements are not always recognised, or capitalised on. *“Health outcomes across different sites within a given country are variable, indicating that some sites have found ways, or ‘workarounds’, to overcome health systems challenges to deliver high quality services – so called ‘positive deviants’”* (GFATM, 2015). They can inspire other operators, but cannot be mechanically ‘replicated’ because they remain context-dependent.

Box 1: Health systems in Challenging Operating Environments

The group of countries and regions classified as Challenging Operating Environments (COEs) are very varied, both across the group and internally. Additionally, healthcare arenas change quickly under stress, demanding the frequent revisiting of both analysis and interventions. However, some traits are more common in COEs compared with more stable settings.

1. Health systems result from multiple adaptations to stress, spontaneous as well as intentional, increasingly diverging from designed structures and processes as the crisis deepens and persists. As a consequence, official policy documents may become irrelevant, and misleading as guidance for external participants.
2. The informalisation and commoditisation of largely privatised service delivery processes become the defining features of these health systems, which are crowded with a variety of autonomous actors. Intervening in isolation is therefore fruitless. Attributing progress or failure to specific actors or actions is often impractical.
3. The inequitable, inefficient and uneven delivery of poor-quality care becomes the norm. Once entrenched after decades of disarray, this state of affairs is resistant to correction. But also the challenges encountered by aid agencies are of uneven intensity, with peripheral health structures found sometimes more responsive than the central level.
4. Governments are frequently contested, and state administrations mistrusted. Recognised health authorities lose clout and legitimacy in the process, while competitors for control, credibility, funding and operational reach may emerge.
5. Trans-border linkages may connect distressed health systems, as people, funds, medicines, germs and ideas move between and within countries. Actual boundaries may move or disappear. Resilience and sustainability acquire a cosmopolitan dimension too, as demonstrated by the rebound of Ebola-stricken Liberia buoyed by the vast global support enjoyed by it.
6. These healthcare arenas are fluid and fuzzy, due to volatile conditions as well as shaky information and defective intelligence. Stable areas coexist with others in turmoil. No stakeholder holds a clear understanding of the whole picture. Additional analytical efforts are required to obtain valid insights.

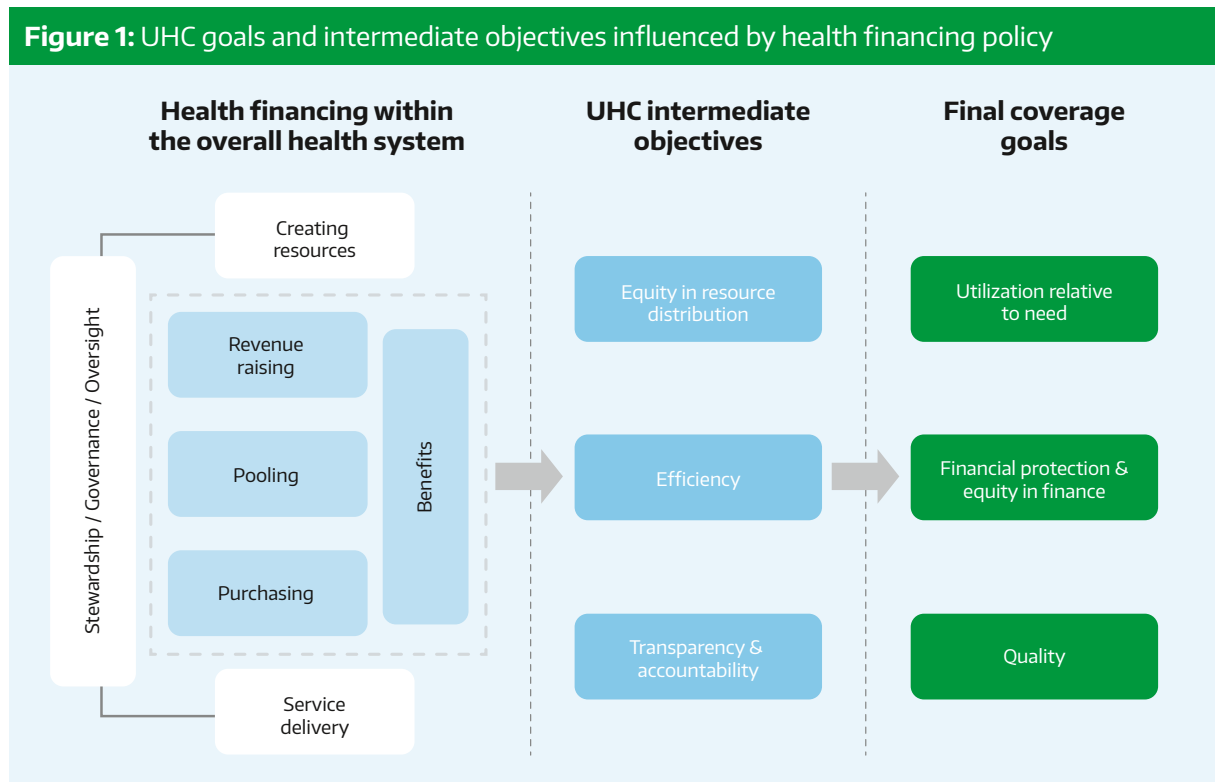
Source: (Witter and Pavignani, 2016)

IMPLICATIONS FOR HEALTH FINANCING

Health financing and its core functions (Figure 1) directly impact on Universal Health Coverage (UHC), which aspires to utilisation of quality health care for all, according to need not means, along with equitable financial contributions and protection against catastrophic health expenditure. Guides to conducting diagnostic assessments of health financing and developing health financing strategies have been produced by WHO (Kutzin et al., 2017; McIntyre and Kutzin, 2016), however, these were not tailored to specific contexts. In this section we consider specific challenges for health financing in FCAS settings, and discuss policy responses

which have been made and what lessons can be drawn from them.

FCAS settings are very heterogeneous, but some common challenges arise in them in relation to health financing, which are discussed below. These are not unique to FCAS settings – many are shared with other low-income countries, for example; however, they may be more common and more marked in FCAS.



Source: (Kutzin et al., 2017)

REVENUE RAISING AND POOLING

Indicators for health financing performance (Kutzin et al., 2017) emphasize the need to move towards a predominant reliance on public or compulsory funding sources, as well as increasing predictability in the level of public and external funding over a period of years, and improving stability in the flow of public and external funds.

GOVERNMENT EXPENDITURE

Public funding is important for reaching UHC as it can provide the most stable, accountable and well-targeted resources. This is documented in wider studies (Kutzin, 2012; Kutzin et al., 2017), though none have distinguished trends in FCAS versus non-FCAS countries.

According to the IMF (2017), FCAS have the following characteristics:

- They have lower economic growth rates compared to non-FCAS, higher inflation, larger general government debt, and high dependence on official development assistance (ODA)
- Tax revenue to GDP in fragile situations tends to be lower than in non-fragile situations (the average tax revenue-to-GDP ratio in FCAS was below 15 percent during 2005–2014, compared to 19 percent in non-FCAS)
- Sources of tax revenue are less diversified than in non-FCAS
- Public expenditure levels are lower than in non-FCAS, especially for social spending
- Capital expenditure is higher than in non-fragile low income countries, reflecting the need to rebuild damaged infrastructure and fill gaps in basic public services such as water, electricity, and transportation.

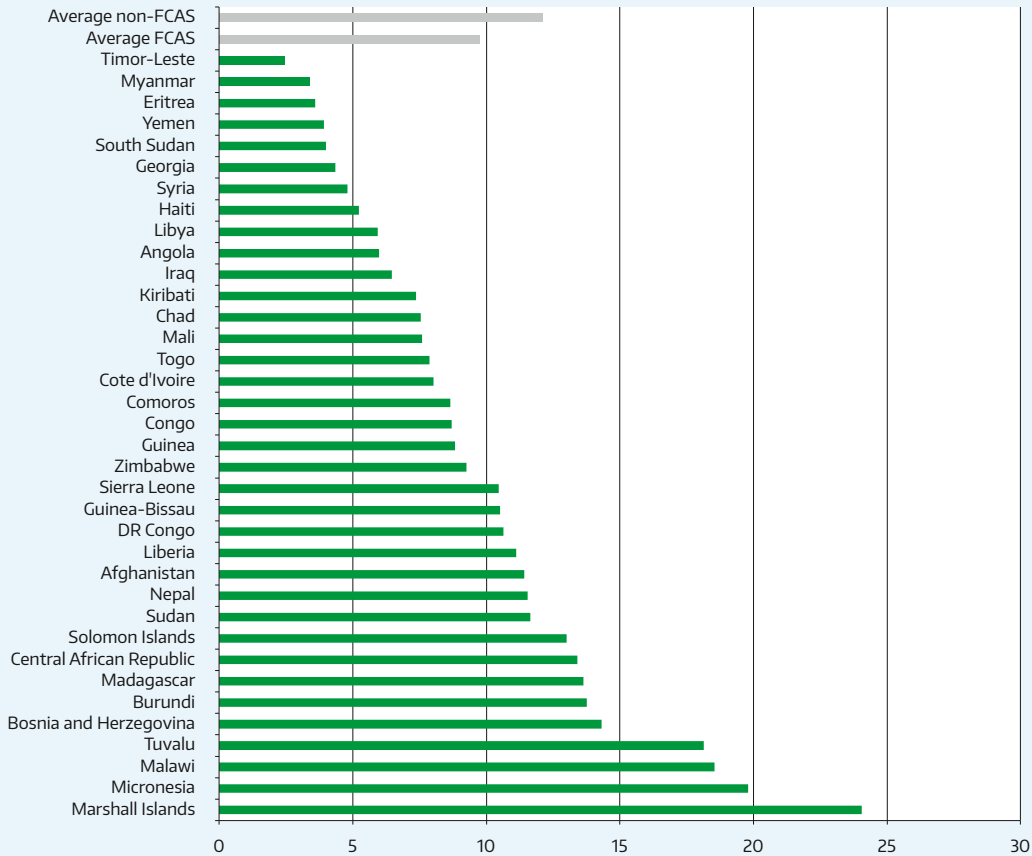
In addition, according to one study, conflicts reduce GDP growth by two percentage points per year, on average (World Bank, 2018a). There is some evidence of a positive ‘revenue peace dividend’ following conflict, but in some cases it’s only a modest recovery compared to pre-war levels (van den Boogaard et al., 2018). All of these clearly create a constraint in relation to fiscal space for health care in FCAS.

National health accounts (NHA) data for 2012-2014 shows a wide spread in terms of proportion of general government expenditure which is devoted to health (Figure 2), ranging from 3-24%. Comparing FCAS and non-FCAS states, there is a small but significant difference in their government commitment to health, with FCAS countries as whole averaging 9.7% of government expenditure on health, compared to 12% for non-FCAS countries (Table 2), though this is largely driven by income, with more FCAS in the low income category.

As a proportion of current health expenditure, government expenditure on health spans the whole spectrum in FCAS countries (2012-2014 NHA data), from a low of around 5% in Afghanistan to more than 80% in some Pacific island states. FCAS have significantly lower average government expenditure on health as proportion of current health expenditures, compared to non-FCAS, which seems to be driven by low income FCAS countries (Table 3). Government expenditure on health is also significantly lower for FCAS in the AFRO and EMRO regions.

Increasing domestic tax revenues is integral to achieving universal health coverage, particularly in countries with low tax bases. However, the challenge is also to raise them in an equitable manner: globally, pro-poor taxes on profits and capital gains

Figure 2: Proportion of general government expenditure devoted to health, FCAS countries, 2012-2014



Data source: (WHO, 2018)

seem to support expanding health coverage without the adverse associations with health outcomes observed for higher consumption taxes (Reeves et al., 2015).

More generally, taxation is seen by some authors as central to the task of state building in post-conflict states (though historically, in European states, it was also central to enabling ‘war and the means of war’) (van den Boogaard et al., 2018). This reflects the urgent need for revenue during the processes of post-conflict reconstruction, as well as the broader governance implications of taxation related to state capacity building and the

expansion of governmental responsiveness and accountability. However, it is likely that conflict will, in fact, reduce revenue mobilization on account of conflict’s negative effects on economic activity, the tax base, tax collection efforts in conflict-affected regions and investment in effective public administration (van den Boogaard et al., 2018).

EXTERNAL FINANCE

Overall, FCAS tend to get less aid for health than predicted based on GDP, although relative to domestic funding, this channel can still be significant. Graves et al. found that

Table 3: Summary of results of quantitative analysis: Proportion of domestic general government health expenditures as a % of current health expenditures, FCAS vs. non-FCAS countries, 2012-2014

		N	Mean	SD	T	p
FCAS		35	31.691	22.414		
Non-FCAS		156	56.314	19.573	6.545	<0.001***
	Income					
FCAS	L	19	18.800	8.351		
Non-FCAS		10	25.193	4.607	2.236	0.034**
FCAS	LM	11	39.467	22.572		
Non-FCAS		38	42.604	16.559	0.509	0.613
FCAS	UM	5	63.573	21.370		
Non-FCAS		46	56.822	13.574	-0.998	0.323
	Region					
FCAS	AFR	19	23.791	13.034		
Non-FCAS		28	39.493	19.476	3.073	0.004**
FCAS	EMR	5	26.260	16.018		
Non-FCAS		14	59.833	19.291	3.470	0.003**
FCAS	EURO	2	46.150	32.692		
Non-FCAS		50	66.062	16.684	1.610	0.114
FCAS	SEAR	3	34.100	24.104		
Non-FCAS		7	50.324	24.444	0.965	0.363
FCAS	WPR	5	64.293	28.302		
Non-FCAS		23	56.540	19.194	-0.753	0.458

Note: no High-income FCAS countries, only one FCAS in AM; *= $p<0.1$, **= $p<0.05$, ***= $p<0.001$

FCAS received an average of \$7.22 per capita, compared to \$11.15 per capita for low-income but stable countries in 2005-2011 (Graves et al., 2015). Relative to stable countries, donors preferred to provide more funding to low-income fragile countries that have refugees or on-going external intervention but tended to avoid providing funding to countries with political gridlock, flawed elections, or economic decline. Other studies linking conflict with aid funding also suggest wide variations in international support. In 2002 and 2003, for example, Afghanistan received

only \$67 per person per year in foreign aid, an amount that is far lower than in other recent post-conflict countries such as Kosovo (\$814), Bosnia (\$249), and East Timor (\$256) (Ahmad, 2004).

Looking across the FCAS countries, the extent of external funding within current health expenditure is hugely varied, ranging from close to zero for Libya to more than 70% for the most aid dependent countries. In general, FCAS countries have a significantly higher average external funding as a proportion of health

expenditures, and aid increases as a proportion of total health expenditure as national income falls. However, the relationship with FCAS status is more complex: we find no significant increase in aid dependence for low income countries (36% of current health expenditure for non-FCAS low income countries, compared to 32% for FCAS low income countries). By contrast, for upper middle-income countries, FCAS status is associated with higher external funding as a proportion of current health expenditure (Table 4).

There is 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). However, data may not support this: the two main trends in health financing post-conflict are an increasing reliance on informal payments and on donor funding (De Vries and Klazinga, 2006). In fact, external support may need to increase over time in order to support the expansion of service provision (Witter, 2012). In any case, more important than volume is arguably how it is used. For example, Cambodia and Rwanda have made impressive progress in expanding coverage of healthcare in the aftermath of conflict, and

Table 4: Summary of results of quantitative analysis: Proportion of external funding as a % of current health expenditures, FCAS vs. non-FCAS countries, 2012-2014

		N	Mean	SD	T	p
FCAS		35	23.913	19.784		
Non-FCAS		120	9.079	14.053	-4.978	<0.001***
	Income					
FCAS	L	18	31.741	15.825		
Non-FCAS		10	35.863	14.437	0.681	0.502
FCAS	LM	11	19.323	23.296		
Non-FCAS		38	12.235	11.882	-1.375	0.176
FCAS	UM	6	8.842	13.611		
Non-FCAS		44	3.156	6.249	-1.773	0.083*
	Region					
FCAS	AFR	18	28.595	18.053		
Non-FCAS		28	22.080	17.242	-1.228	0.226
FCAS	EMR	6	4.956	8.223		
Non-FCAS		11	2.780	4.278	-0.727	0.478
FCAS	EURO	2	2.062	0.780		
Non-FCAS		23	1.959	3.099	-0.046	0.964
FCAS	SEAR	3	21.557	15.969		
Non-FCAS		7	3.247	3.966	-3.053	0.016**
FCAS	WPR	5	36.555	24.019		
Non-FCAS		19	15.988	17.828	-2.142	0.044**

Note: no High-income FCAS countries, only one FCAS in AM; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

both have relied heavily on international funding (Witter and Bertone, 2018). Mobilising domestic resources in an equitable way is complex and it may therefore be more important in the post-conflict period to focus on maximising external aid in the short to medium term, especially for low income countries, but making it more predictable and stable and using it more effectively.

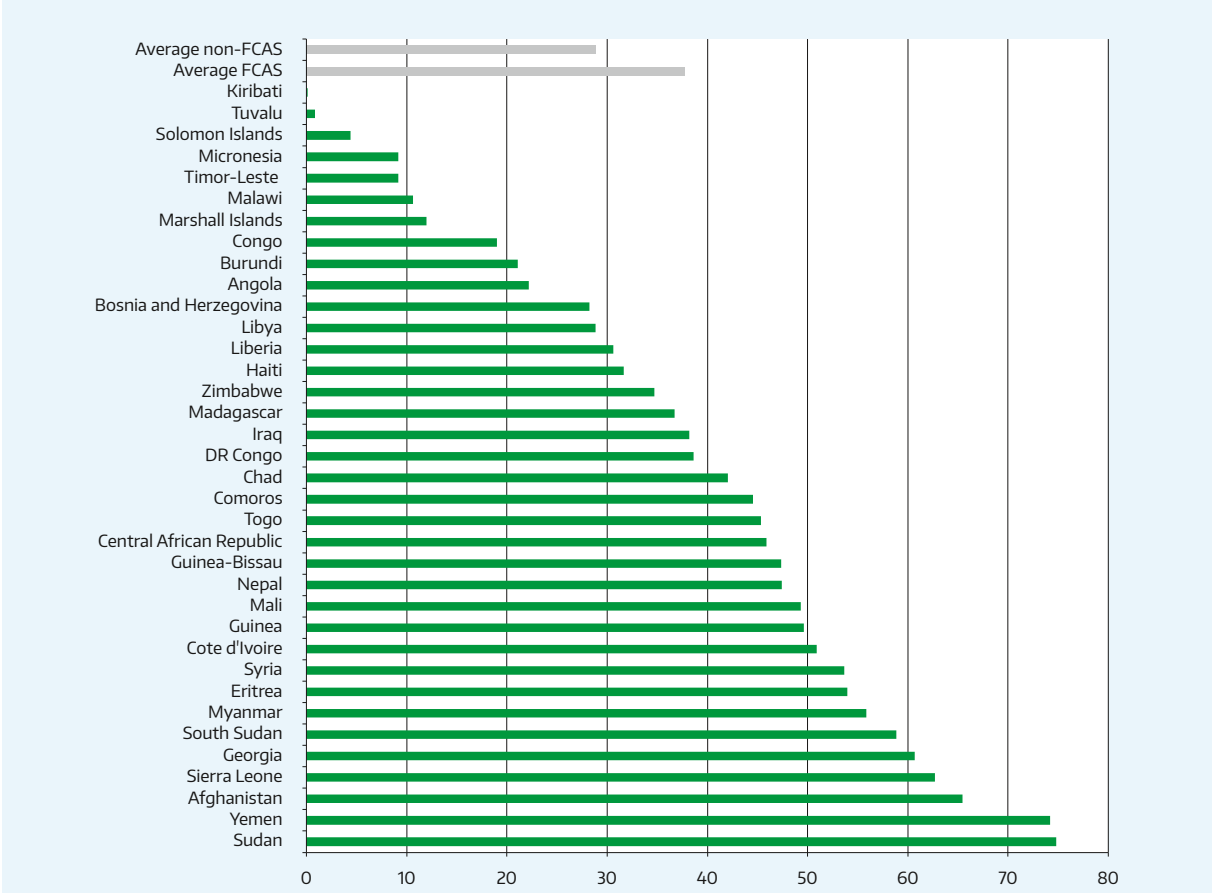
Dependence on external financing is about more than resource flows: it brings with it external influences on plans, policies and implementation capacity, which can be supportive or undermining of local leadership and capacity, depending on the

circumstances. Financing tends to be framed by donor agendas, particularly where the local state is weak, and local planning frameworks are either inadequate or developed with extensive technical assistance (Cometto et al., 2010; Pavignani et al., 2013). Transaction costs can also be very high, reducing the value of transfers to beneficiaries.

OUT OF POCKET PAYMENTS

Looking at FCAS countries as a group, the level of out of pocket payments (Figure 3) as a proportion of total health expenditure is clearly very varied, ranging from under 10% to 74% (for Sudan). FCAS countries have a

Figure 3: Out of pocket payments (% of current health expenditure), FCAS countries, 2012-2014



Data source: (WHO, 2018)

significantly higher average level of out of pocket payments, but there is no significant difference between FCAS and non-FCAS after controlling for income (Table 5).

The gap left by a contracting or absent public purse is filled by households, often supported by family remittances from abroad, especially in countries with a large diaspora (Hill et al., 2014; Weiss Fagen and Bump, 2005). However, evidence on the amount of funding flows from remittances is limited to particular case studies. A study on expenditure at private health providers in three zones of Somalia, for example, found

that salaries and remittances were the main reported sources for families to finance health care, with 23.5% of households relying on remittances (Lipcan et al., 2018).

Once all these financial contributions are added together, total health expenditure may attain considerable levels, with the highest proportion usually coming from out-of-pocket expenditure, especially for medicines, despite the level of poverty of the involved population (Pavignani et al., 2013). In Zimbabwe, for example, the dramatic decline in the health budget translated into an increased reliance on user fees, which has had a significant

Table 5: Summary of results of quantitative analysis: Proportion of out of pocket payments as % of current health expenditure, FCAS vs. non-FCAS countries, 2012-2014

		N	Mean	SD	T	p
FCAS		36	37.750	20.563		
Non-FCAS		156	28.888	16.783	-2.732	0.007**
	Income					
FCAS	L	19	42.983	13.633		
Non-FCAS		10	34.606	17.549	-1.425	0.166
FCAS	LM	11	37.453	29.149		
Non-FCAS		38	39.191	17.597	0.246	0.807
FCAS	UM	6	21.723	13.378		
Non-FCAS		46	30.296	14.881	1.340	0.186
	Region					
FCAS	AFR	19	40.223	14.177		
Non-FCAS		28	27.388	17.267	-2.682	0.010**
FCAS	EMR	6	55.867	19.150		
Non-FCAS		14	31.321	18.404	-2.703	0.015**
FCAS	EURO	2	44.470	22.924		
Non-FCAS		50	26.773	15.350	-1.580	0.121
FCAS	SEAR	3	37.487	24.873		
Non-FCAS		7	39.748	20.842	0.150	0.885
FCAS	WPR	5	5.300	5.182		
Non-FCAS		23	25.803	19.965	2.249	0.033**

Note: no High-income FCAS countries, only one FCAS in AM; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

impact on service users, and the poorest in particular (Buzuzi et al., 2016).

OVERALL EXPENDITURE AND POOLING

Overall expenditure on health as a proportion of GDP ranged widely from less than 2% to 17% in 2012-2014 for FCAS countries, with means of between 6-9%, depending on the income group. There was no significant difference between FCAS and non-FCAS countries (Table 6).

In relation to volatility, total expenditure tends to be less changeable, but internally its

composition can change – a crisis, for example, often reduces public expenditure, which is substituted by out of pocket expenditure. In Iraq, for example, the combination of the Isis insurgency in 2011-13, followed by the halving of oil prices in 2014 led to a drop in government expenditure as a proportion of total health expenditure from around 75% in 2011 to around 25% in 2015, which was exactly mirrored by a rise in out of pocket spending (Mòdol, 2018).

WHO emphasises the importance within pooling of enhancing redistribution of prepaid funds; ensuring that funding sources

Table 6: Summary of results of quantitative analysis: total health expenditures as a % of GDP, FCAS vs. non-FCAS countries, 2012-2014

		N	Mean	SD	T	p
FCAS		36	6.790	3.667		
Non-FCAS		156	6.725	2.502	-0.126	0.900
	Income					
FCAS	L	19	6.335	2.677		
Non-FCAS		10	6.047	0.942	-0.328	0.746
FCAS	LM	11	6.184	3.546		
Non-FCAS		38	5.764	2.273	-0.472	0.639
FCAS	UM	6	9.341	5.809		
Non-FCAS		46	6.510	1.967	-2.491	0.016**
	Region					
FCAS	AFR	19	5.896	2.652		
Non-FCAS		28	5.884	1.990	-0.018	0.986
FCAS	EMR	6	5.950	2.033		
Non-FCAS		14	5.155	2.225	-0.750	0.463
FCAS	EURO	2	8.702	1.351		
Non-FCAS		50	7.937	2.253	-0.474	0.638
FCAS	SEAR	3	3.091	2.389		
Non-FCAS		7	4.710	2.987	0.823	0.434
FCAS	WPR	5	12.301	4.675		
Non-FCAS		23	5.845	2.404	-4.555	<0.001***

Note: no High-income FCAS countries, only one FCAS in AM; *= $p<0.1$, **= $p<0.05$, ***= $p<0.001$

are complementary; reducing fragmentation, duplication and overlaps; and simplifying financial flows (Kutzin et al., 2017). Historical performance in relation to UHC has been significantly associated with the level of pooled financial resources for health per capita (Global Burden of Disease Health Financing Collaborator Network, 2018). Low levels of prepayment and pooled funding in FCAS settings, as indicated by the high rates of out of pocket payments, is problematic in relation to all UHC dimensions. Contextual factors underlying this include low trust in public institutions, leading to fragmentation of risk pools, as well as disruption of pooling mechanisms which may occur during conflict (Ljubić et al., 1999). In humanitarian settings, an influx of refugees or internal displacement of populations add to the segmentation, with populations either unprotected or protected by different agencies with varying mandates, resources and coverage.

SUB-GROUP AND TREND ANALYSIS IN REVENUE COLLECTION AND POOLING

Analysis of chronic FCAS countries and conflict-affected FCAS show similar results to those described above, except that there was no difference in external expenditure as a proportion of total health expenditure for conflict-affected states, reflecting the literature on lesser donor engagement in these environments. Total health expenditure as a proportion of GDP is also lower compared to non-conflicted FCAS ($p=0.051$). The other significant differences also tend to be accentuated in conflict-affected FCAS.

Annex 4 contains more detailed analysis of selected health financing indicators by region. It highlights different patterns across WHO regions, with more significant challenge in

the East Mediterranean Region (EMR) and African Region (AFR):

- Government expenditure on health as a proportion of total health expenditure is only significantly lower in FCAS in AFR and EMR
- Government expenditure on health as a proportion of general government expenditure is only significantly higher ($p<0.1$) for FCAS in Western Pacific Region (WPR)
- FCAS have significantly higher out of pocket expenditure as a proportion of total health expenditure in AFR and EMR; FCAS have significantly lower in WPR; and there is no difference in the European Region (EUR) or Southeast Asian Region (SEAR)
- External expenditure as a proportion of total health expenditure is only significantly higher for FCAS in SEAR and WPR
- Total health expenditure as a proportion of GDP is significantly higher for FCAS in the WPR alone

In relation to trend analysis:

- Government expenditure on health as a proportion of general government expenditure, external expenditure as a proportion of total health expenditure and government expenditure as a proportion of total health expenditure have increased slightly for both FCAS and non-FCAS over 2007-14.
- For out of pocket expenditure as a proportion of total health expenditure and total health expenditure as a proportion of GDP, however, there has been an improvement in FCAS performance over time, while non-FCAS have remained steady.

- However, the different starting position and wider range is clear from figures in Annex 4. Much of the gains in the latter two indicators appear to be driven by upper-middle income countries.

By WHO region, performance has also varied. In summary:

- Out of pocket payments have been steady for non-FCAS, but decreasing over time for FCAS in the EUR (which is now at non-FCAS levels), SEAR and WPR (now below non-FCAS levels).
- External expenditure as a proportion of total health expenditure is steady for non-FCAS, but decreasing for FCAS in EMR (which is now at non-FCAS levels) and increasing for FCAS in WPR (now above non-FCAS levels).
- Government expenditure on health as a proportion of total health expenditure has been increasing for FCAS in EURO, SEARO and WPRO, but decreasing for FCAS in EMRO
- Government expenditure on health as a proportion of general government expenditure has been decreasing for FCAS in the Americas (AM) and EMR, but increasing for FCAS in EURO (now at non-FCAS levels), SEAR (now at non-FCAS levels) and WPR (now above non-FCAS levels)
- Total health expenditure as a proportion of GDP appears to have increased rapidly for FCAS in WPR (now well above non-FCAS levels); the increase for FCAS is more gradual in AM, EURO and SEAR, and there has been a slight decrease for FCAS in EMR.

PURCHASING

Desirable attributes for purchasing systems (Kutzin et al., 2017) include that they:

- Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination
- Move away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement
- Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements
- Move towards a unified data platform on patient activity, even if there are multiple health financing/health coverage schemes.

ASSESSING NEEDS AND PERFORMANCE

There is limited literature on health care purchasing in FCAS settings, but typically in these information on population needs and provider performance tends to be limited. Purchasing itself tends to be fragmented, including in some contexts by a plethora of external development and humanitarian actors – for example, in DRC, Provincial Health Authorities have up to 30 contracts with external partners (Witter and Bertone, 2018).

PROVIDER PAYMENTS

In many FCAS, allocations of public funds are dominated by salaries and other inputs such as medicines and supplies, with higher level facilities such as hospitals capturing the bulk of funds. For example, in DRC the personnel expenditure doubled from 42% in 2007 to more than 80% of government expenditures

over 2009–2012, while the share of operating expenditure declined from around 26% in 2007 to 8% in 2013. The share of capital expenditure also declined from 32% in 2007 to 3% in 2012, but then jumped up again to 27% in 2013 (Barroy et al., 2014).

As in many low income FCAS, there is no cash allocation to primary care facilities, leaving them dependent on fees. For example, a study in Papua New Guinea found that less than half of the health facilities that submitted budget requests received any funding as a result of doing so, and the average value of the funding received was much lower than budgeted for. As a consequence, user fees raised are greater than the subsidy allocations, and are the most widely collected and reliable source of revenue for health facilities (Wiltshire and Mako, 2014). Similarly, in the DRC most of the government budget is allocated to investment and a much smaller budget (only one-quarter compared to the investments level) is allocated to ‘operations’, with no discernible geographical pattern and unpredictable execution (Barroy et al., 2014). Fee for service payments also dominate in the private (for-profit and not-for-profit) and informal sectors.

Insurance systems, which are more common in middle-income FCAS countries, generally pay user fee for services payments, with copayments, which do not control prices effectively. Meanwhile, contracted NGOs, in recovery situations, usually operate with line-item budgets, negotiated during the bidding process for aid funding. Humanitarian funds are more typically awarded as block budgets, typically to NGOs (Mòdol, 2018). Humanitarian NGOs themselves tend to operate primary provision directly, while purchasing referral services by reimbursing public or private hospitals.

Providers in the public sector are often simultaneously restricted in their expenditure by limited and rigid funding rules but also ineffectually regulated: in an environment with complex remuneration and under-funding, it is hard to ensure that health workers and providers follow public priorities (which themselves are often very contested or unclear) (Bertone and Witter, 2015a; Ensor and Witter, 2001).

MONITORING PAYMENT AND OUTCOMES

Health information systems tend to be partial in most FCAS and commonly operate in silos, making analysis linking funding with outputs (never mind outcomes) challenging. Budget and expenditure data are often disconnected and are typically managed by different teams to those working on other inputs (such as staffing, procurement, drugs) and on outputs. This makes performance management very challenging. Between international actors, including development and humanitarian sectors, sharing of data and coordination of monitoring is often poor.

BENEFITS PACKAGES

Principles underlying benefits packages (Kutzin et al., 2017) include that there should be clarity on the population’s legal entitlements and obligations; the population should be aware of both their legal entitlements and their obligations as beneficiaries; and that promised benefits, or entitlements, should be aligned with provider payment mechanisms.

ENTITLEMENTS

The very notion of an entitlement is incongruous in many FCAS settings, where

capacity, legitimacy and security deficits result in lack of explicit or even implicit public entitlements to health care. Access to health care is more commonly perceived as resulting from personal and family resources, wider contacts and networks, requiring negotiation and transactions at different levels. While public policy may offer theoretical entitlements, their realisation is dependent on funding and strong implementation, which are often lacking, leading to low population awareness and limited real entitlement.

Most FCAS countries lack clearly defined health care benefit packages at different levels of the health system, as well as data on their resourcing needs, although the definition of basic packages of health services (BPHS) is an area which has received support and investment in some FCAS countries, as highlighted below. For example, in the DRC a list of services to be provided at primary and secondary levels is defined nationally, but this does not correspond to specific entitlements for the population which vary based on donor funding and preferences and across areas of the country (Jacobs et al., n.d.; Mathew and Abiodun, 2017). The misalignment between BPHS and benefit packages presents a missed opportunity to reinforce good care seeking practices. Referral systems are often poor, leading to care seeking at referral, not primary level, and over-consumption of inappropriate services, such as unnecessary diagnostics and antibiotics.

PROVISION

Where there is lack of confidence in government by donors, or lack of capacity on the health system side, or simply strong external preference for non-state actors, funding is often channelled to (international) non-governmental organisations (NGOs),

which can increase effective coverage in the short term but also carries risks of patchy provision (NGOs often focus on specific areas) and higher costs. This pattern of contracting out is most common in post-conflict or post-crisis settings, such as Haiti, Cambodia, Afghanistan, Liberia and South Sudan. Provision for refugees is also often provided through parallel services, which can cause tensions with host populations, as well as longer term challenges of transition (Blanchet et al., 2016). Another challenge, in particular for multilateral organisations, is to work in settings where the state and therefore the government is unrecognized (Garber et al., 2018).

More generally, the capacity to regulate the pluralistic market of formal and informal, public and private (and hybrid) providers may be constrained by low capacity and funding for enforcement, leading to variations in quality and content of health care services. Private (for profit or not) providers of services, training and pharmaceuticals are often left to evolve and proliferate by the absent state, without regulation (Hill et al., 2014). Policies may be coordinated at central level, but external actors, such as NGOs, at local level (whose presence and distribution is often a legacy of the crisis period) may undermine these efforts: in Sierra Leone, NGOs at district level were shown to influence the HRH incentive package and redefine local health priorities (Bertone and Witter, 2015b).

UHC OBJECTIVES

RESOURCE ALLOCATION

Literature on resource allocation in FCAS settings is limited (Witter, 2012). However, the wider political economy is such that

Box 2: Challenges for countries hosting refugees

While the countries that are in emergency suffer disrupted health services and may have to cope with growing numbers of IDPs, their neighbouring countries (even if previously stable and not formally recognised as FCAS) often have to host large numbers of refugees.

The very nature of emergencies means these neighbouring countries are usually unprepared to suddenly take on health care responsibility for the influx (which is often made up of large numbers of people of all ages) and, again, there is added pressure on already overstretched health systems.

The situation becomes even more complex when refugees from one country (e.g. from Iraq into the Syrian Arab Republic) have to face another crisis in their host country as a result of a new conflict, or when natural disasters such as drought hit those already dealing with conflict. In such situations, IDP and refugee health priorities can overlap.

The main service provision challenge for countries that neighbour a country in emergency is to deal with the large numbers of refugees and migrants and ensure their access to health care. These groups face:

- a lack of availability of good quality services
- a lack of access to the service providers
- inability to deal with local systems
- a lack of awareness and information about health entitlements
- language and cultural differences
- administrative hurdles (such as a need for paperwork). This is especially difficult for refugees coming from countries in acute crisis and for undocumented/irregular migrants).

In terms of financial protection, those that are able to migrate to neighbouring countries following an emergency can face immense financial hardship when seeking health care. They are not usually covered by the local financial protection schemes available to nationals, leading to high out-of-pocket expenditure. This can be particularly hard as they may have no employment in the host country and have complex care needs. Delays in seeking treatment over fears about costs affect health-seeking behaviours and contribute to avoidable mortality (WHO EMRO, 2018).

resources can be relatively easily captured by elite groups, and few FCAS countries operate formal resource allocation formulae based on need and other population-based indicators to ensure horizontal equity.

TECHNICAL EFFICIENCY

Again, the published evidence is limited but gaps in critical resources and rigidity about how they can be used can make even limited

resource inefficient (for example, with public budgets often focussed on salaries, leaving a lack of funds for drugs, outreach, supplies and supervision, especially for frontline PHC services). In addition, countries with a shortage of trained staff face considerable pressure on wages for staff with transferable skills, such as doctors, nurses and midwives (McCoy et al., 2008; Witter et al., 2016b). Efficient pharmaceutical purchasing – typically the second most costly input into

health care services – also requires robust systems which are often lacking.

ALLOCATIVE EFFICIENCY

In a context where decision-making has often become ad hoc and data on population needs is lacking, the risks of poor allocation and capture of resources to serve the well-connected minority is high, meaning that priority services are neglected. External funding also often leaves important gaps – for example, an analysis of humanitarian funding for reproductive health between 2002 and 2013 found comparatively limited attention and programming for family planning and abortion care in particular (Tanabe et al., 2015). Research suggest that global health initiatives (such as GAVI and the GFATM) are increasingly investing in conflict-affected countries, which has helped to rapidly scale up health services, strengthen human resources, improve procurement, and develop guidelines and protocols. Negative influences however can include distorting priorities within the health system, inequitable financing of disease-specific services over other health services, diverting staff away from more essential health care services, and limited flexibility and responsiveness to the contextual challenges of conflict-affected countries (Patel et al., 2015).

GOVERNANCE

In a context of weak, contested and sometimes oppressive governance, there is typically limited reporting, transparency and accountability for health financing decisions and resources. Where there is substantial external influence, these can become even more non-transparent (Bertone et al., 2018c) and institutionally fragmented (Beaston-Blaakman et al., 2011). These challenges

reflect low capacity, resources and, sometimes, legitimacy, and the challenges of managing complex systems.

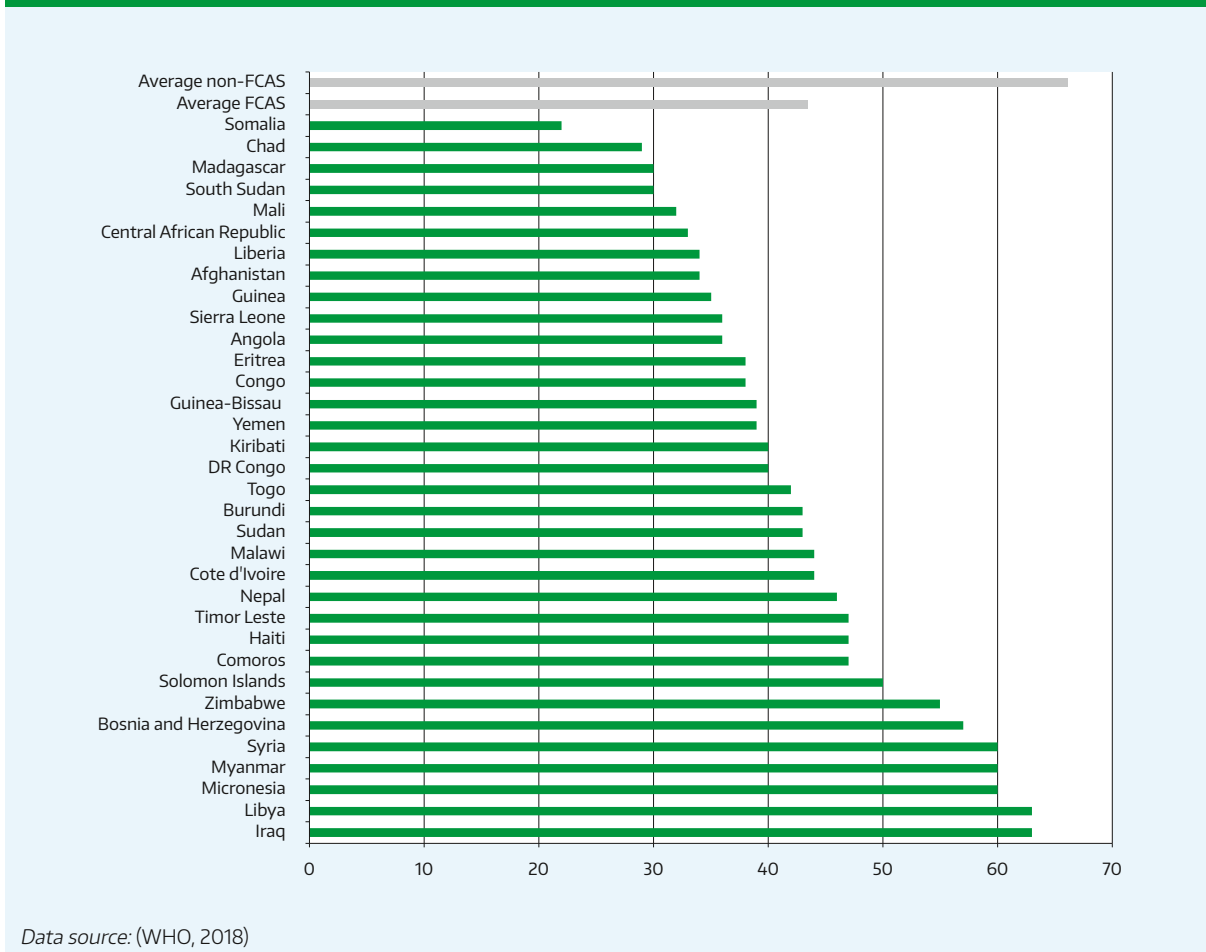
The post-crisis moment offers risks and opportunities for the development of a national state: risks include capture of resources by privileged elites or increased opportunities for patronage and nepotism; opportunities include a new settlement in which governing actors revive the social contract through equitable financing, distribution of resources (such as infrastructure and staff) and services. Although it is under-studied, health financing has the potential to communicate political and social values, such as social solidarity (through cross-subsidies and pooling); inclusion (e.g. targeting poorer areas); equity (e.g. reducing financial barriers); reconciliation (e.g. resources allocated to opposition areas); human rights (e.g. establishing constitutional rights to health care); participation (e.g. civil society involvement); and confidence in public stewardship (e.g. donor resources channeled through public systems) (Witter, 2018). There is emerging evidence that public health measures, including equitable access to basic health care, may contribute to peace-building- for example, reconciling warring sides – in the aftermath of conflict (Christensen and Edward, 2015; Sen and Faisal, 2015). However, the literature on health system linkages to state-building is contested and empirical evidence is hard to establish and hence limited (Eldon et al., 2008; Percival, 2017; Witter et al., 2015).

UHC GOALS

EQUITABLE ACCESS

Given disruption to services and financing, and underlying economic and social challenges,

Figure 4: UHC coverage³ index (2015), FCAS countries, 2015



achieving access to health care (including preventive, curative and palliative) according to need is likely to be more challenging in FCAS settings. Overall coverage for essential health care (UHC index for 2015) shows a wide range of performance, from around 20% for Somalia up to more than 60% in Iraq (Figure 4). Differences between FCAS and non-FCAS settings are significant overall, and remain significant for all income levels and regions (Table 7).

Patterns of equity across FCAS settings as a whole have not been systematically studied and there is a lack of recent benefits incidence analyses which allow for comparison, but

individual case studies exist. For example, a historical analysis of Cote d'Ivoire from 1893 to 2013 highlights how armed conflict has exacerbated historically inherited challenges to the health system including unequal distribution of health services (Gaber and Patel, 2013). An analysis in Palestine suggests that the worse-off have disproportionately greater needs for all levels of care. However,

³ WHO definition for this index: coverage of essential health services defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population.

Table 7: Summary of results of quantitative analysis: UHC coverage index (%), FCAS vs. non-FCAS countries, 2015

		N	Mean	SD	T	p
FCAS		35	43.486	11.189		
Non-FCAS		147	66.156	12.438	9.870	<0.001***
	Income					
FCAS	L	20	37.800	7.838		
Non-FCAS		10	43.100	6.724	1.825	0.079*
FCAS	LM	11	49.727	10.071		
Non-FCAS		38	56.632	10.839	1.888	0.065*
FCAS	UM	4	54.750	12.816		
Non-FCAS		44	68.068	6.708	3.511	0.001**
	Region					
FCAS	AFR	20	37.350	7.393		
Non-FCAS		28	50.036	11.286	4.392	<0.001***
FCAS	EMR	6	50.333	13.140		
Non-FCAS		14	65.500	10.331	2.780	0.012**
FCAS	EURO	2	61.500	6.364		
Non-FCAS		47	73.277	6.334	2.575	0.013**
FCAS	SEAR	3	51.000	7.810		
Non-FCAS		7	57.429	9.502	1.023	0.336
FCAS	WPR	3	50.000	10.000		
Non-FCAS		19	66.211	12.568	2.115	0.047**

Note: no High-income FCAS countries, only one FCAS in AM; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

with the exception of primary-level, utilisation of all levels of care appears to be significantly higher for the better-off (Abu-Zaineh et al., 2011) – a finding which is common to other settings, but may be more pronounced in FCAS. While much of the inequality in utilisation appears to be caused by the prevailing socioeconomic inequalities, detailed analysis attributes about 30% of inequalities to heterogeneity in healthcare-seeking behaviour across socioeconomic groups of the population. A study analysing the equity of the utilization of health services for 2010 in Afghanistan finds that utilization

of inpatient and outpatient care and antenatal care was equally distributed among income groups. However, the poor used more public facilities while the wealthy used more private facilities. There was a substantial inequality in the use of institutional delivery services. Poorer women had a lower rate of institutional deliveries overall, in both public and private facilities, compared to the wealthy. Location was an important factor in explaining the inequality in the use of health services (Kim et al., 2016).

Financial constraints are a major reason for

postponing or foregoing health care in many FCAS settings (Laokri et al., 2018). Meanwhile, FCAS settings are often characterized by high levels of spending on medical care abroad⁴, given health system challenges – spending which is generally highly inequitable.

Policy-makers need to respond to population movement during and after crises. Urban settings often attract displaced populations yet suffer from poor healthcare planning (Pavignani and Colombo, 2009). There needs to be investment to expand service coverage to slum areas and displacement camps

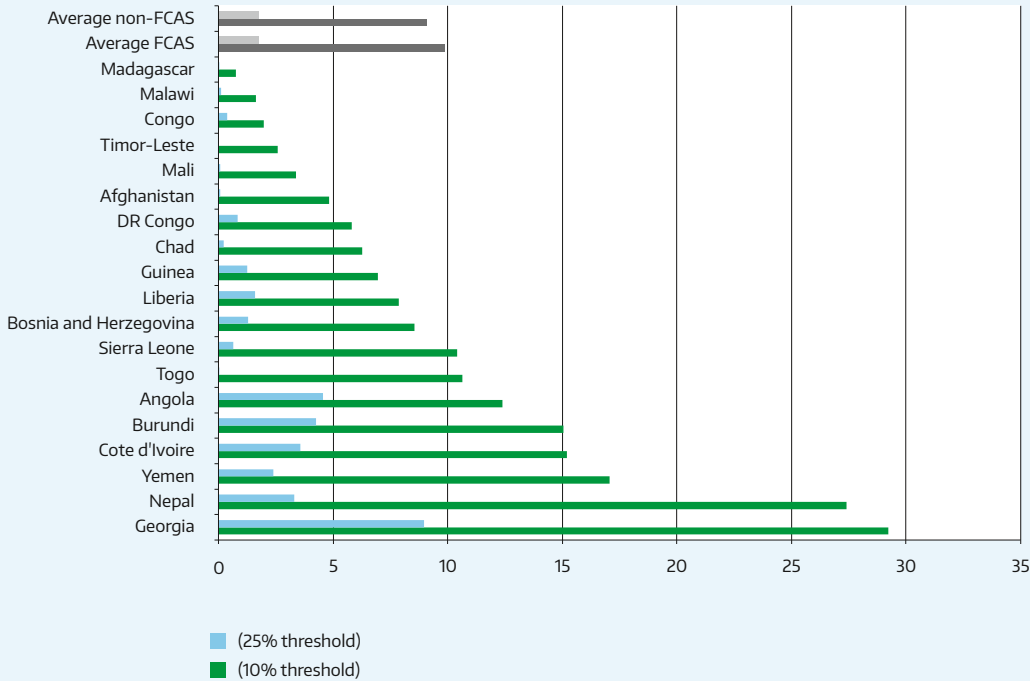
on the assumption that populations will remain there for a significant period of time. Policy-makers need to react to changes once populations begin to return to their homes as people may then lose access to healthcare if similar services are not available in places of origin. For example, refugees returning home from displacement camps in Uganda reportedly shifted from formal to informal healthcare providers due to impoverishment and the costs of care (ReBUILD, 2016).

FINANCIAL PROTECTION

Information on levels of catastrophic payments by households is not available for all FCAS countries, but for those available, the level ranged from around 1% in Madagascar to

4 Of total health expenditure in Afghanistan in 2011-12, 6% was managed by the Ministry of Public Health, and 10% by NGOs, however 17% was spent abroad (Mòdol, 2018).

Figure 5: Catastrophic payments, FCAS countries (most recent data points; dates vary)



Data source: (WHO, 2018)
 Note: calculations are based on last year for which data are available. As a consequence some data may not reflect the current situation or may not match the FCAS status (see Annex 1 for further information).

Table 8: Summary of results on catastrophic expenditures (population with household expenditures on health greater than 10% of total household expenditure or income), FCAS vs. non-FCAS countries, dates vary

10%		n	Mean	SD	T	P
FCAS		19	9.896	8.071		
Non-FCAS		110	9.065	7.540	-0.439	0.661
	Income					
FCAS	L	12	8.422	7.197		
Non-FCAS		8	5.909	4.451	-0.878	0.392
FCAS	LM	5	13.204	11.334		
Non-FCAS		31	9.296	7.938	-0.964	0.342
FCAS	UM	2	10.470	2.701		
Non-FCAS		33	10.217	8.643	-0.041	0.968

Note: no High-income FCAS countries; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

Table 9: Summary of results on catastrophic expenditures (population with household expenditures on health greater than 25% of total household expenditure or income), FCAS vs. non-FCAS countries, dates vary

25%		n	Mean	SD	T	P
FCAS		19	1.765	2.317		
Non-FCAS		110	1.776	2.124	0.019	0.985
	Income					
FCAS	L	12	1.035	1.397		
Non-FCAS		8	1.009	0.961	-0.046	0.964
FCAS	LM	5	3.062	3.619		
Non-FCAS		31	2.077	2.369	-0.802	0.428
FCAS	UM	2	2.905	2.312		
Non-FCAS		33	1.889	2.056	-0.676	0.504

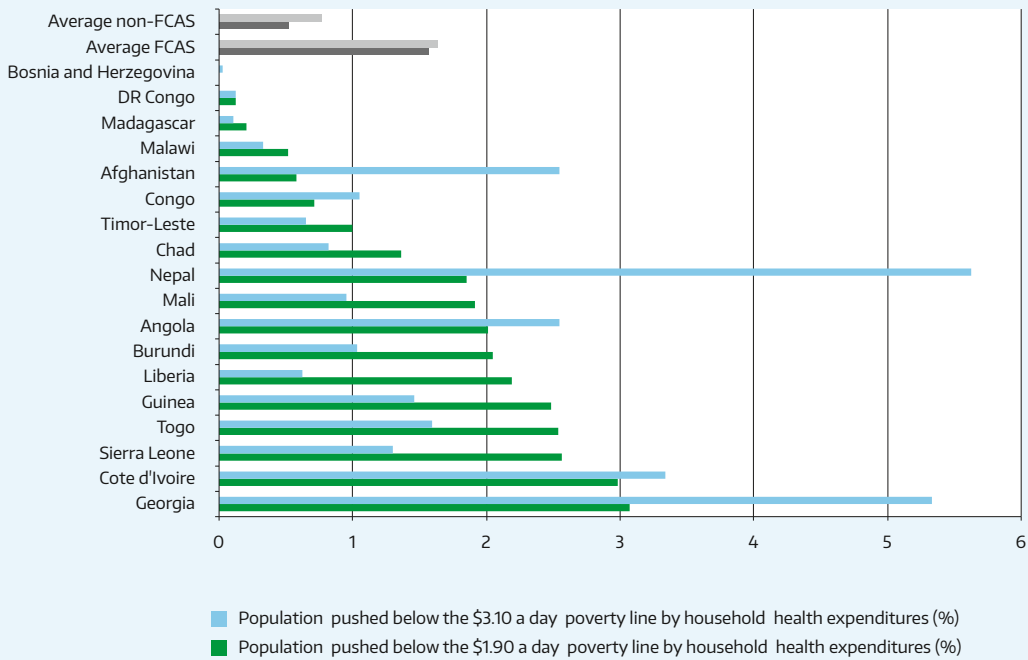
Note: no High-income FCAS countries; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

more than 25% in Georgia and Nepal, using the 10% of household expenditure threshold (or close to zero up to almost 10%, if the 25% of household expenditure is used) (Figure 5). For all country income groups, FCAS have higher rates of catastrophic expenditure. Rates also rise for higher income countries,

reflecting likely demand suppression at lower income levels (Tables 8-9).

Between 0 and 5% of the population are pushed below the poverty line in the FCAS countries for which we have data (Figure 6). Overall, FCAS have significantly higher

Figure 6: Population impoverished by health expenditure, FCAS countries (most recent data points; dates vary)



Data source: (WHO, 2018)

Note: calculations are based on last year for which data are available. As a consequence some data may not reflect the current situation or may not match the FCAS status (see Annex 1 for further information).

Table 10: Summary of results on impoverishing expenditures (Population pushed below the \$1.90 a day poverty line by household health expenditures), FCAS vs. non-FCAS countries, dates vary

\$1.90		n	Mean	SD	t	p
FCAS		18	1.563	1.018		
Non-FCAS		98	0.517	0.936	-4.296	<0.001***
	Income					
FCAS	L	12	1.530	0.936		
Non-FCAS		8	1.569	1.059	0.086	0.932
FCAS	LM	4	1.940	1.259		
Non-FCAS		26	1.099	1.322	-1.190	0.244
FCAS	UM	2	1.005	1.421		
Non-FCAS		29	0.296	0.449	-1.887	0.069*

Note: no High-income FCAS countries; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

Table 11: Summary of results on impoverishing expenditures (Population pushed below the \$3.10 a day poverty line by household health expenditures), FCAS vs. non-FCAS countries, dates vary

\$3.10		n	Mean	SD	t	p
FCAS		18	1.637	1.664		
Non-FCAS		98	0.767	1.112	-2.804	0.006**
	Income					
FCAS	L	12	1.376	1.507		
Non-FCAS		8	1.020	0.719	-0.618	0.544
FCAS	LM	4	2.592	2.176		
Non-FCAS		26	1.721	1.486	-1.031	0.312
FCAS	UM	2	1.290	1.782		
Non-FCAS		29	0.632	0.720	-1.152	0.259

Note: no High-income FCAS countries; *= $p < 0.1$, **= $p < 0.05$, ***= $p < 0.001$

rates of impoverishment at both poverty line thresholds, and this is also significant for upper middle-income countries for the 1.90USD threshold (Tables 10-11).

Health financing policy and wider socio-economic developments influence levels of catastrophic illness, alongside household determinants. In Sierra Leone, the incidence of catastrophic health expenditure decreased significantly from approximately 50% in 2003 to 32% in 2011, as it moved away from the immediate post conflict period (Edoka et al., 2017) – a result of changing endowments and health system factors, including the Free Health Care Initiative of 2010.

Financing incidence in FCAS settings has received limited attention. However, where reliance on out of pocket payments is high, there is an increased likelihood of regressive financing of health care. A study of current health care financing schemes in the Occupied Palestinian Territory, for example, confirms the pro-rich character of out-of-pocket

payments, compared to the progressivity of the government health insurance scheme (Abu-Zaineh et al., 2008).

CROSS-CUTTING ISSUES

PUBLIC FINANCIAL MANAGEMENT

Weak public financial management systems contribute to many of the challenges above. An analysis of funding for immunization in DRC, for example, found that bottlenecks in the budget process and disbursement of funds were one of the causes of limited domestic resources for the programme. Critical bottlenecks included: excessive use of off-budget procedures; limited human resources and capacity; interference from ministries with the standard budget process; dependence on the development partner's disbursements schedule; and lack of budget implementation tracking. Results show that the health sector's mobilization rate (i.e., the ratio between allocated funds and those made effectively available) was 59% in 2011.

For the credit line specific to immunization program activities, the mobilization rate for the national Expanded Program for Immunization (EPI) was 26% in 2011 and 43% for vaccines in 2010 (Le Gargasson et al., 2014). A recent public expenditure review in DRC (Barroy et al., 2014) confirms that, despite the reform attempts, the fiscal management performance remains suboptimal at best, with key challenges especially in terms of budget preparation and execution. It is important to note that, as with many of the challenges identified, these are not unique to FCAS settings but may be more extreme there.

The relationship between corruption, health financing and FCAS countries is underexplored and is likely to be complex: weaker institutions and resource constraints may create more opportunities and pressures which increase corruption, though the volumes managed in better resourced systems will be higher. External finance with disbursement pressures and sometimes weak controls are another risk factor, and can develop into negative spirals with institutional capacity, as illustrated in Sierra Leone, where a GAVI accounting scandal was the result of but also had significant negative impact on the Ministry of Health and Sanitation's capacity (Bertone et al., 2018c; Nossiter, 2013; Witter, 2016). Either way, preventing and sanctioning corruption at all stages of the health financing pipeline is a constant challenge. 5 to 10% of the health budget in Cambodia was unaccounted for at the central level alone, according to one study (Hussman, 2011). However, most of the literature on health care and corruption focuses on more stable settings (Vian, 2008).

Similarly to taxation, some authors state that successful transition from conflict and fragility hinges on the quality and legitimacy of PFM

systems (Porter et al., 2011). However, PFM is often fragmented and parallel cash flows and procurement systems are in place – for example, by donors, NGOs, global initiatives. This is a major source of inefficiency in fragile settings. Porter et al (2011) point to how PFM systems in FCAS often develop asymmetrically. Formal aspects of modern systems are layered with informal arrangements, and modern PFM mechanisms remain applied only to a small part of the main revenue sources. For example, a study on Burundi (CABRI, 2014) found that indicators relating to the use of country systems declined over 2006-2011 period and that relatively little overall donor funding to Burundi passes through national public finance systems. Indeed, donors' preference is for funding modalities which do not use country systems such as delivery of programmes through NGOs and projects, mostly due to the capacity weaknesses in systems and ministries as well as concerns about the governance environment, especially regarding the independence of the judiciary, media and the capability and bias of the police, in a post-conflict environment like Burundi.

OPPORTUNITIES FOR REFORM

Conflict and institutional weakness can block systemic reforms (for example, in Ukraine, (Lekhan et al., 2015)). Loss of infrastructure and trained staff imposes constraints to planned reforms, such as the rebuilding of the Kosovo Health Insurance Fund post-conflict (Percival and Sondorp, 2010). However, the aftermath of crises can offer windows of opportunity to accelerate progress towards UHC, as well as for promoting health systems resilience (Witter and Hunter, 2017d). Those windows of opportunity may take some time to emerge while the state re-builds capacity and legitimacy for health system. This

was the case in Sierra Leone, where it took several years for the policy environment to be suitable for government- and donor-backed healthcare reforms that led to the Free Health Care Initiative (Bertone et al., 2014), however momentum for reform was soon lost (Witter et al., 2016a). Reforms, where undertaken, can leave a lasting legacy for the system – the decision to contract out services post-conflict, for example, can shape service delivery over subsequent decades, as happened in Cambodia (Vong et al., 2018).

RESILIENCE

Although not specific to health financing, the literature on resilience highlights general features which can support health systems in

surviving and managing shocks of different types, duration and intensity. Capacities such as change management (Barasa et al., 2017) ability to anticipate change, integrate knowledge, manage multiple players and create socially legitimate institutions (Blanchet et al., 2017) echo the literature on FCAS and highlight important qualities for health financing functions too. In one study, for example, the willingness to delegate responsibility and allow flexibility of resource use at local level was an important factor in resilience, allowing for absorptive, adaptive and transformative approaches in dynamic and challenging contexts of crisis and population movements (Alameddine et al., 2018).

POLICY RESPONSES

Policy responses to the challenges outlined above are focussed on certain areas, with gaps in relation to others, and also in relation to the literature which assesses their effectiveness and effects.

REVENUE RAISING AND POOLING

Much of the literature on revenue raising and pooling in FCAS has been focused on management of external funds and on addressing financial barriers in the form of user fees through various mechanisms. There has been limited attention paid to how far there is fiscal space for health in FCAS and how that can be expanded. Specific country analyses suggest that there may be space to expand domestic resource mobilization (for example, in Sierra Leone, (Witter et al., 2016b)). However, this area merits more attention across the group as a whole.

IMPROVING FLOW AND USE OF EXTERNAL FINANCE

Different mechanisms for donor coordination exist, such as Health Pooled Funds, Multi-Donor Trust Funds (MDTFs), Sector-wide approaches (SWAs) and ‘state-building contracts’ (recently used by the EU – (Bernardi et al., 2015)). Some have been more commonly adopted to support health systems in FCAS states, such as MDTFs (World Bank, 2011). In these settings, the emphasis has often been on coordinating with—rather than working through—governments (Hughes et al., 2012), particularly when trust or capacity

is low, or international rules prohibit direct financing, such as in Zimbabwe (Salama et al., 2014).

In relation to pooling funds, Commins et al. (2013) highlight potential advantages, such as donor coordination and harmonisation; operation on a larger scale; lower transaction costs; pooling risks in fragile contexts; supporting dialogue with the government, capacity development and service delivery. However, potential challenges include slow disbursement; dissatisfaction with results, leading donors to pursue parallel channels of funding. The study also raises important trade-offs which apply more broadly to support for health systems in FCAS, such as balancing speed of service delivery versus capacity building of government systems; low tolerance of fiduciary risk versus capacity development; donor attribution of results versus enhancing government ownership, alignment, and use of country systems; and achieving short term, visible impacts versus investment in slower, long-term (sustainable) change (Commins et al., 2013).

Pooled funding mechanisms are often used to contract NGO delivery of services, particularly during the transition from humanitarian relief to the early-recovery phase. For example, in South Sudan, pooled donor funding supported primary health care in ten states, where one NGO was designated as lead per county, with some success but also challenges of limited funding levels and absorptive capacity (Jones et al., 2015). In Liberia, the Health Sector Pool Fund supported an increase in health sector funding and the extension of the BPHS

to a majority of public health facilities by 2010. This was supported by an accreditation process. The Pool Fund also strengthened country ownership and coordination between government, local NGOs, and international NGOs by enabling the Ministry of Health and Social Welfare to contract service provision (Lee et al., 2011). Access was extended, although it remained limited for rural Liberians (Kruk et al., 2010b).

Different aid instruments may allow for less fragmented and more aligned PFM systems. Aid through national systems may appear more risky than donors delivering projects directly or through non-governmental organisations (NGOs) or humanitarian channels, but these risks can be managed. Strengthening national capacity for procurement, accounting and auditing, reporting and programme implementation is clearly part of the solution and may take time (Manuel et al., 2012). Pooled funds, including sector pooled funds as well as broader MDTFs, can provide closer alignment with national priorities, consolidate small projects into scalable national programmes, use national systems and harmonise and simplify the transaction costs of foreign assistance. While there are examples of pooled funds in FCAS settings, these include small and highly earmarked pooled arrangements, so their effectiveness is likely to be varied.

In humanitarian settings, there is a move to break down institutional silos across aid agencies by moving towards impartial and comprehensive needs assessments and country-based pooled funds (pooling funds across sectors). In this new model, a humanitarian coordinator and an advisory board that includes donor and agency representatives decide funding allocations independent of agency mandates, in order to

respond in a more cohesive way to user needs (Konyndyk, 2018).

Institutionally, it has been common in some FCAS settings for donors to support a semi-independent programme management unit within Ministries of Health to take forward policy reforms and implement agreed policies. Within Afghanistan, for example, for years after the end of the conflict, service delivery was carried out largely by NGOs, funded by international donors, and managed by the Grant and Contracts Management Unit (GCMU) of the MoPH, which was considered by some a “Ministry within a Ministry”. The GCMU was heavily supported by donors. It is important that short term solutions do not become long-term problems, in terms of parallel systems. In 2009, the GCMU was restructured into the Health Economics and Financing Directorate (HEFD) with the aim of broadening the scope of the Unit (e.g., to conduct important economic analyses) and to strengthen the capacity of the MoPH (Beaston-Blaakman et al., 2011).

CONTRIBUTORY MECHANISMS

There are some examples of insurance being extended to increase UHC in FCAS settings and in response to crises, although the evidence on effectiveness of this approach is limited and issues of lack of trust and lack of capacity affect ability to collect contributions. For example, in Palestine, Governmental Health Insurance (GHI) was initially compulsory for public sector employees. Later, GHI was expanded to the informal and private sectors on a voluntary basis, with reduced/waived premiums for some groups. However, premiums and exemptions were not in line with ability-to-pay and did not improve vertical equity (Abu-Zaineh et al., 2008). Although GHI is only compulsory for public sector workers, special and vulnerable

groups are given free membership. For instance, about 60,000 families were granted free coverage during the 2001 Palestinian Intifada (Hamdan et al., 2003).

In line with wider literature emphasizing risks of adverse selection and small risk-pools, the experience of community-based health insurance (CBHI) has been mixed. In a CBHI pilot in five provinces of Afghanistan enrolment and cost-recovery were modest (enrolment rate was 6% of eligible households; cost recovery rates ranged up to 16% of total operating costs) and no evidence of reduced out-of-pocket health expenditures was observed at the community level, though CBHI members had markedly higher utilization of health services (Rao et al., 2009). Insecurity, low quality of healthcare, poor awareness among the population and limited willingness to pay, as well as low technical capacity are all identified as barriers to expansion of health insurance in Afghanistan (Zeng et al., 2017). By contrast, in Rwanda, the scaling up of micro-insurance (*mutuelles*) – which do not share the same features as the typical CBHI, with high state subsidies and strong incentives to ensure high coverage – appears to have contributed to improved healthcare utilization and decreased out-of-pocket spending, including among the poor, alongside other health financing reforms, namely performance-based financing (PBF) and fiscal decentralization (Sekabaraga et al., 2011). There is however evidence that members of female-headed households are less likely than those of male-headed households to be enrolled in the CBHI programme (Finnoff, 2016).

In Yemen, options for social health insurance are being considered for the post-conflict phase. Before the conflict, against a backdrop of lack of formal social health protection,

a series of small-scale and often informal solidarity schemes developed, and a number of public and private companies set up health benefit schemes for their employees (Holst and Gericke, 2012). Given the existing lack of trust at the community level, any future scheme should build on preexisting programs already trusted in the community (Fuss, 2016).

USER FEE EXEMPTIONS OR TARGETED EXEMPTIONS FOR VULNERABLE GROUPS

The general recommendation to reduce payments at the point of use for health care to shift toward greater risk pooling, equitable access and financial protection is even more pertinent in FCAS settings, where population vulnerability is higher and ability to pay is likely to be lower. In humanitarian and complex emergencies, there is an agreed interagency policy to suspend user fees for essential health care services (IASC, 2010). There has been less consensus in wider FCAS settings. However, a number of studies in FCAS settings highlight the potential of population-based exemptions. For example:

A quasi-experimental study in Afghanistan showed that abolishing user fees for the Basic Package of Health Services (BPHS) did not affect quality of care but did improve utilisation. User fees raised only limited revenues and slowed the rate of increase of service utilization in Afghanistan. In 2008, the government abolished primary care fees, citing the results of this study (Steinhardt et al., 2013).

A study by *Medicins sans Frontieres* in 6 FCAS settings (Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti and Mali) found that user fees were found to result in low utilisation of public health facilities,

exclusion from health care and exacerbation of impoverishment, forcing many to seek alternative care. Financial barriers affected 30–60% of people requiring health care. Exemption systems targeting vulnerable individuals proved ineffective, benefiting only 1–3.5% of populations. Alternative payment systems, requiring ‘modest’ fees from users (e.g. low flat fees) did not adequately improve coverage of essential health needs, especially for the poorest and most vulnerable. Conversely, user fee abolition for large population groups led to rapid increases in utilisation of health services and coverage of essential healthcare needs (Ponsar et al., 2011).

Nepal introduced free delivery services for births in public facilities in 2005. A study reveals that free delivery care increased the likelihood of using public sector maternity services early in pregnancy, and lowered the likelihood of neonatal mortality. The results on neonatal mortality persisted with longer programme exposure, although the effects were smaller in magnitude (Lamichhane et al., 2017).

An evaluation of the Free Health Care Initiative, which provided free care for expectant and lactating mothers and children under five, in Sierra Leone concluded that it was one important factor contributing to improvements in coverage and equity of coverage, despite weaknesses in implementation in a number of core areas, such as drugs supply (Witter et al., 2016b).

However, maintaining effectiveness of exemptions over time in weak health systems has been challenging, particularly where public financial support for health facilities is low (see, for example, in DRC (Maini et al., 2014)). In addition, many countries have multiple approaches to increasing financial

access for vulnerable populations, which are not harmonized. Where this has been done, longer term sustainability is likely to be enhanced – for example, in Sudan, where a free-standing policy of free care for caesareans and under-five care was brought under the umbrella of the National Health Insurance Fund (Witter et al., 2013).

In addition, MSF has recently stressed a worrying trend of reintroduction of user fees despite the UHC commitment and the evidence on their inequitable effects, including in particular for populations affected by conflict, epidemics and crises (MSF, 2017).

HEALTH EQUITY FUNDS

One related approach to protecting low income households from health care costs has been Health Equity Funds (HEFs), which were piloted in post-conflict Cambodia since 2000. These utilize third party organizations (non-governmental organization) to identify the poorest and refund specific health care costs. This avoids the conflict of interest for health care staff (who, in granting waivers, risk reducing their facility revenues, often without adequate reimbursement), and has been shown to improve access and reduce out of pocket spending on health care (Ir et al., 2010). The HEFs could be expanded to cover wider population groups and become semi-autonomous purchasing agencies (Axelson, 2018). HEFs are now being piloted in Laos, alongside other reforms (Thomé and Pholsena, 2009).

Outside South-East Asia, similar experiences of ‘equity funds’ to exempt the poorest in the communities from paying user fees for healthcare services have also been implemented including in fragile and conflict-affected settings, although under slightly

different designs. For example, a number of PBF projects (see below, under ‘purchasing’) include arrangements to refund facilities for services provided for free to the very poor (Fritsche et al., 2014; Mayaka et al., 2011). However, the equity fund is often administered directly by the NGO/agency implementing PBF rather than by a third-party one. These experiences have been rarely assessed *per se*, i.e., not independently of the PBF programme of which they were a part. One exception is a pilot in northern Cameroon (Flink et al., 2016), which revealed challenges in the identification of the poorest, as well as other barriers to access for the very poor.

A specific case also piloted by PBF projects is the reimbursement by the implementing NGOs of health services provided to internally displaced people (IDPs) at time of acute crisis. Such IDP-targeted equity funds have been introduced in the design of PBF projects in DRC, Central African Republic and Cameroon (Banga-Mingo et al., 2014; Bertone et al., 2018b; Shu Atanga et al., 2015).

Additionally, in some fragile settings such as the DRC, forms of equity funds have been introduced and managed by NGOs as one component of broader projects, with the aim of improving access to care for the very poor (Dijkzeul and Lynch, 2006; Gerstl et al., 2013). The NGO Handicap International has piloted equity funds covering rehabilitation services in Rwanda, Mali and Togo (Gerbier and Botokro, 2009). In Syria, a WHO project contracted national NGOs to cover the user fees of vulnerable households obtaining services from private providers (WHO, 2017). However, few, mostly anecdotal descriptions of these arrangements exist and little or no assessment has been conducted on the projects.

DEMAND-SIDE FINANCING

Demand-side financing, such as vouchers and conditional cash transfers, have been used in FCAS settings, as in other low-income countries, to stimulate use of specific services and address access barriers, especially for reproductive health care. In countries such as Yemen and Pakistan, vouchers have been used with some success to increase access to family planning by poor households from public and private facilities (Boddam-Whetham et al., 2016). However, there are preconditions for effectiveness, which include that adequate services must be in place, with some population access and capacity to manage the voucher scheme. In Yemen, despite worsening conditions in 2014, a voucher programme was able to channel funds to facilities at a time when funds flowing were highly erratic, enabling them to address stock-outs of drugs and supplies at the local level and protect the supply of critical maternal newborn health services for poor women and their families (Grainger et al., 2017).

In Syria, 18,000 women received maternal and reproductive services through vouchers. The programme resulted in an increase in the use of antenatal and post-natal care, and institutional delivery, allowed women to choose providers, improved equitable access to RH services, improved staff and women’s satisfaction and led to a reduction in turn-over of health professionals. However, some challenges remained in terms of targeting of population most in need, controlling the overbilling and unnecessary procedures, persistent security barriers and difficulties in accessing health facilities, difficulty in monitoring private sector hospitals, and finding adequate financial resources (Balan, 2015).

In Afghanistan, a conditional cash transfer (CCT) programme in 2009-2011 was

Box 3: Transition from conflict to early recovery and post-conflict – the case of Liberia

For the health sector, the transition from a humanitarian, emergency phase to early recovery and post-conflict is often seen as focusing on three types of interventions, which are normally considered sequential: (i) meeting the immediate health needs of conflict-affected populations, (ii) restoring essential health services, and (iii) rehabilitating the health system. In terms of funding, there is often a contraction due to the reduction of humanitarian funding and the shift towards development aid, which may be slow to take up (so-called 'transitional funding gap') (Canavan et al., 2008), or government funding which (as described above) may take longer to materialise. While service delivery during crisis and the immediate aftermath are usually provided by humanitarian NGOs, the role that NGOs may play during the following phase depends on decision made (for example, whether to contract them or not) and the type of NGOs involved may change. Finally, as the transition progresses, the focus also shifts from providing or restoring essential services to an increased attention to institution building for the health systems, including strengthening the capacity of the government to define priorities, ensure governance and stewardship of the health system (Brinkerhoff, 2008).

THE CASE OF LIBERIA

Early transition period (2003–2006)

In this period, healthcare delivery in Liberia maintained a humanitarian approach. 77% of the functioning facilities were supported by international NGOs meeting the immediate needs of the populations (Canavan et al., 2008). However, these efforts were uncoordinated and there was no medium or long-term vision for the rehabilitation of the health system. By the end of the period, three years after the end of the war and with the establishment of a new government, humanitarian donors felt that their mandate and their role in Liberia were coming to a close. As development funding was slow in coming, there were concerns about a funding gap for the sector (Sondorp and Coolen, 2012).

Early policy development and Liberia Partners Conference (2006–2007)

With a sense of urgency due to the potential funding gap and the limited capacity of the government to ensure service provision, in August 2006, a workshop was held to bring the main stakeholders together to identify the major challenges and the key future policy orientations to ensure donor coordination as well as alignment and support to the Ministry of Health vision. A number of recommendations emerged from the workshop, including the need to define a Basic Package of Health Services (BPHS) and the option of contracting NGOs to provide health services (Sondorp and Coolen, 2012). In February 2007, the government and the main donors met in Washington, DC for the "Liberia Partners Conference", where pledges of support from donors were obtained (Canavan et al., 2008). In this way, the transitional funding gap was averted both by increasing new funding and extending humanitarian (ECHO) funding (Hughes et al., 2012).

After 2007 a change in funding sources took place with the shift from humanitarian to development funding. This led to the withdrawal of a number of humanitarian NGOs, which handed over some of the facilities that they were supporting to other NGOs, while others, especially at secondary level, faced funding and capacity constraints and were unable to provide services (Canavan et al., 2008).

Box 3: Contd.

Implementation of the National Health Policy and Plan (2007–2011)

By 2007, the new National Health Policy and Plan (2007–2011) was launched which defined the priorities of the health sector and focused in particular on decentralization and the definition of a BPHS, while acknowledging the need for continued support from donors (Sondorp and Coolen, 2012).

Donors opted for different approaches to support BPHS service delivery. Some donors (e.g., USAID, EU) continued to fund their programme or NGOs directly, while others chose to set up a *Pool Fund* which allowed the MoH to have a more direct influence over fund allocations (Sondorp and Coolen, 2012). The Health Sector Pool Fund was established in March 2008 under the oversight of a representative steering committee chaired by the Minister and managed by an external firm. Importantly, Pool Fund expenditures relied on national systems, including procedures for procurement, financial management, audit, monitoring and evaluation (Hughes et al., 2012). In 2012, the Pool Fund had attracted over US\$ 40 million in total contributions from four donors (DFID, Irish Aid, UNICEF and UNHCR), which represented on average 10% of total donor support for health. Although a relatively small proportion, some saw it as critical to improve the capacity of the MOH, especially in the area of financial management, donor coordination and stewardship. Additionally, funding from the Pool Fund supported over one-third of public health facilities, via contracts with NGOs or contracting-in arrangements (Hughes et al., 2012; Lee et al., 2011).

With the establishment of these policies, it was possible to move from humanitarian to development approaches. However, it was clear that the government and MoH lacked the systems and capacity to ensure provision of health services. As of 2009, a number of different contracting arrangements came into place with international NGOs and faith-based organisations, in the form of performance-based management contracts, or management contracts through grant arrangements (without performance-based elements), as well as one pilot 'contracting in' arrangement in one county (Sondorp and Coolen, 2012). A process of accreditation of facilities also started (Cleveland et al., 2011).

In summary, over the transition period Liberia was able to implement a series of complementary health and health financing reforms. It appears that these have contributed to guarantee sufficient and predictable funding during the transition and to ensure continued service delivery. However, one key area where improvement has been slow is the strengthening of institutional capacity and human capital (Sondorp and Coolen (2012). Additionally, vulnerabilities remained, especially at community level (for example, in surveillance, coordination, testing, and social mobilization), which set the stage for the 2014 Ebola epidemic (Abramowitz, 2016). A 2010 assessment found that, although there had been progress in the provision of basic services, some communities and in particular the rural ones still had limited access to health care, and that health provision was skewed to services favoured by donors (such as HIV testing and malaria treatment) (Kruk et al., 2010b). Petit et al. (2013) pointed to a number of implementation challenges, including for health workers, who appeared to have limited understanding of the BPHS and associated it with low salaries, difficult working conditions, and limited support.

evaluated as successful in stimulating demand for MCH services and increasing utilization of targeted services, in particular when both families and community health workers were targeted (Lin and Salehi, 2013). However, there was also evidence of non-economic barriers to care which impeded women's access (Witvorapong and Foshanji, 2016).

HEALTH FINANCING IN EMERGENCY SETTINGS

Humanitarian funding (13% of overall ODA – (Spiegel, 2018)) is focused on preparedness, acute and protracted crises. In these settings, there are heightening risks of outbreaks and epidemics, which requires rapid responses from local, national and international levels. Challenges include persistent under-funding of the humanitarian response plan, including most recently in Yemen, where WHO's response plan for 2016 received 24% of total requested funding (Qirbi and Ismail, 2017). Funding per capita tends to be very variable and not necessarily related to needs.

New options for raising external funding for refugee health care are proposed, including combined indexed insurance and catastrophe bonds, the establishment of a 'Refugee Health Financing Emergency Facility' in the pre-emergency phase, and use of the World Bank's IDA concessional loan program to support refugee hosting countries (Spiegel et al., 2018), although these are yet to be fully elaborated and tested.

There is also recognized need for better interface between humanitarian and development actors on analysis, planning, coordination and pooling in the health sector, internationally and at national level (UN, 2016). At the beginning of a crisis, funding can decrease as the usual donors leave and

emergency funds take longer to be triggered. This was the case in Mali, for example, following the invasion of the Northern regions of the country by terrorist groups and a coup in March 2012, when donors suspended official development assistance, except for support to NGOs and humanitarian assistance and took months before organizing alternative and only partial solutions to resume aid to the health sector (Paul et al., 2014). Equally, the transition from humanitarian stages to development can leave financing gaps, and in protracted crises none of these phases are clear and distinct in any case.

There has been a long-standing debate about user fees for health care during crisis situations (Derderian, 2014). Humanitarian NGOs have always strongly advocated in favour of raising funds internationally and providing free care to communities during crises, and in particular to refugees, IDPs and vulnerable groups. However, in many weak and underfunded health systems patient fees are still considered as an acceptable 'survival strategy' of the system. MSF experience in DRC has shown reluctance by health facilities to declare outbreaks, because this would imply suspension of patient fees (Derderian and Schockaert, 2010). Meanwhile, until around 2008-2010, some donors, like ECHO, supported cost-recovery (i.e. fees covering partial costs of services) as a developmental strategy: they believed that the introduction of fees is inevitable, conformed with local policy and practice, and that bringing them in at an early stage would contribute to building a sustainable, locally financed health system in the longer term (Hands, 2004). However, the contrary view strongly argued that cost-sharing is likely to raise little money, have a significant negative impact on equity, which cannot be effectively mitigated via exemption mechanisms, have a negative impact on

efficiency, result in unequal access to care, potentially tip individuals and families into destitution via catastrophic health expenditure, potentially hamper efforts to control epidemic infectious disease, needlessly increase the complexity of programming in already challenging environments, potentially damaging the motivation of local staff and the relationship between local and expatriate staff (Poletti and Sondrop, 2004). Arising from this debate, a shift in approach ensued and consensus has been reached that user fees for primary health care services should not be applied during humanitarian situations, given the humanitarian principles of impartiality and human rights (DG ECHO, 2009; IASC, 2010).

UNHCR advocates that essential primary health care and emergency services be provided free of charge to refugees during an emergency (UNHCR, 2012). Furthermore, certain essential services such as childhood vaccinations, antenatal and delivery care, and communicable disease control (e.g. tuberculosis) should be provided free to all refugees during the post-emergency phase. Fees for all other services depend upon the context, but UNHCR advocates that they should not be higher than those prices charged to nationals. Furthermore, vulnerable refugees should be identified and a suitable safety net provided for them to ensure access to preventative and curative health services. The agency advocates that government services are accessible to and used by refugees whenever possible. However, in neighbouring countries like Jordan, this has put a tremendous pressure on national health financing: from 2012 to 2014 Syrian refugees living outside refugee camps were entitled to use free services at Ministry of Health facilities, however the cost of this led to restrictions being introduced (Axelson, 2018).

Moreover, issues emerge during protracted emergencies or in fragile countries that keep moving between emergency and post/pre-emergency phase and where both humanitarian and development NGOs are present and where services are *not* provided for free to the entire population. In a paper on MSF's experience along the Liberia-Cote d'Ivoire border, although the difficulties posed by protracted crises are recognised, the authors still argue for the suspension of user fees. "Protracted crises and fragile post-conflict settings have challenged the co-existence, and even the linear continuum, of relief and development aid. This 'backsliding' from development to emergency remains a substantial challenge to aid; yet, in exactly such cases, it also presents the opportunity to ensure access to medical care that is much more urgently needed in times of crisis, including the suspension of user fees for medical care" (Derderian, 2014). Similar situations have emerged in the case of Eastern DRC and CAR, where ideological and operational clashes have occurred between humanitarian and development NGOs (Bertone et al., 2018b; Derderian and Schockaert, 2010).

NGOs have dealt in a variety of ways to address the issue of fee charging in protracted crises. In DRC, Malteser International suggested introducing flat-rates for health care services. For the poorest 10% of the population, free access is assured through so-called equity funds to be administered according to health committee recommendations. However, they note that "once the project ends, the population will have to pay again for their health service" (Gerstl et al., 2013). This raises the problem of sustainability of free or subsidized care after the acute phase of the crisis ends.

Where insurance systems are already established, purchasing insurance coverage on behalf of vulnerable, displaced and refugee populations is a strategy used by a number of aid agencies, both in FCAS countries and also countries which host refugee communities (UNHCR, 2012). Clearly, this has the potential advantage of utilizing and investing in existing health financing infrastructure. In Iran, the government and the UNHCR launched the health insurance scheme (HISE) for Afghan refugees in 2011 through a semi-private insurance company, as the government did not allow refugees access to the national system at that time. HISE was made available to registered refugees on an individual and voluntary basis, with a system of premiums and co-payments (refugees in Iran are allowed to work). For those who could not pay and met the vulnerability criteria, the UNHCR covered their costs. In 2015, negotiations were concluded with the government to allow refugees access to the national HISE (Spiegel et al., 2018). In Sudan, a pilot using the National Health Insurance scheme to cover IDPs in Darfur had some success, based on the existing institutional strength of the NHI in that state (Witter, 2015).

Cash transfers have been growing in use in humanitarian contexts. They are used in most sectors, including food security, livelihoods, shelter, water and sanitation, protection, health, nutrition and education, but account for no more than 6% of humanitarian assistance (World Bank, 2016). Cash transfers are most effective and efficient when provided as ‘multipurpose cash’ – one grant to address multiple needs across sectors (Fabre and Aggiss, 2017). Proponents of cash- and voucher-based approaches argue that they can be more cost-effective and timely, allow recipients greater choice and

dignity, and have beneficial knock-on effects on local economic activity. Sceptics fear that they are often impractical because they incur additional risks of insecurity and corruption, and argue that cash may be more difficult to target than commodities. Even where these approaches are feasible, there are concerns that women may be excluded, that cash may be misused by recipients and that it may have negative effects on local economies and could fuel conflicts. Vouchers are often used when cash is not seen as possible or appropriate. This may be due to donor constraints, to a desire to ensure that a particular type of good or commodity is purchased by the recipients, because of security fears about the use of cash or because of market weaknesses (Harvey, 2005).

Most studies of cash-based approaches focus on non-health benefits, such as food security. A recent review concludes that in terms of costs, cash transfers can be an efficient strategy for providing humanitarian assistance. Unconditional cash transfer programmes have a lower cost per beneficiary than vouchers which, in turn, have a lower cost per beneficiary than in-kind food distribution (Doocy and Tappis, 2017). A variety of card-based systems and mobile transfers can also reduce costs and increase speed. However, with relation to health care, unconditional cash transfers may not work as well as they do for food, as health needs are not distributed equally across populations and out-of-pocket payments for health costs are not predictable (WHO & Global Health Cluster, 2018).

PURCHASING

There has been limited attention to purchasing in FCAS beyond the topic of contracting and, more recently, some attention to performance-

based financing (PBF) as a potential approach to strengthening health care purchasing.

CONTRACTING OF SERVICES

Contracting out services to NGOs is an approach which has been adopted for health care purchasing in many FCAS settings, often when public service delivery capacity is limited or donors are unable or unwilling to fund public services directly. These contracts are sometimes funded out of pooled funds, and linked to the development of basic packages of services.

Haiti is one of the earliest examples of performance-based contracting: NGOs have been contracted since 1999 to provide primary health care services, in a context of violence, poverty, limited government leadership and the inability of the Haitian government to ensure access to basic health services. Some success in increasing coverage and capacity is reported (Eichler et al., 2009). Incentives and technical support both contributed to increased primary health care service delivery (Zeng et al., 2013). However, in another challenging environment, South Sudan, logistical and security constraints have created severe implementation challenges for two performance-based contracting programmes (Morgan, 2005).

Contracting can also occur with public facilities – internal contracting – and indeed some countries have moved over time from contracting out to a hybrid model, followed by internal contracting. In Cambodia, since the late 1990s, contracting has been used to accelerate the recovery of the rural health system after the devastation of the Khmer Rouge period. Contracting out was piloted between 1999 and 2002/3. This was followed by “hybrid contracting” and, from

2009, Special Operating Agencies, which test a form of internal contracting (Vong et al., 2018). Jacobs et al describe the transition over a 3-year period in a health district to hybrid contracting in Cambodia (Jacobs et al., 2010). The transition from NGO-managed to government-managed contracting was achieved by focusing on all the building blocks of the health care system and ensuring an acceptable financial remuneration for the staff members of contracted health facilities. The latter was attained through performance subsidies derived from financial commitments by the central government and revenue from user fees. Performance management had a crucial role in the gradual handover of responsibilities. Not all responsibilities were handed back to government over the case study period—notably the development of performance indicators and targets and the performance monitoring (Jacobs et al., 2010). In the SOA model, hospitals and health centers were contracted by the provincial health department as Special Operating Agencies (SOAs) and provided with greater management autonomy (Khim and Annear, 2013).

There are reported increases in utilization of services by the general population and the poor under the SOAs (Vong et al., 2018), although robust evaluation is challenging given the selection approach to SOAs and the additional resources provided to them. More interesting from the evolution of models in Cambodian is the iterative learning, and gradual resumption of national leadership despite continued financial and technical reliance on the plethora of international agencies which have contributed to the health sector over the past two decades.

In Afghanistan, a few inter-linked policies were introduced, the most important of

which were defining a package of priority health services, known as the basic package of health services (BPHS), contracting with NGOs to deliver the basic package of health services, and prioritizing monitoring and evaluation of health sector performance (Loevinsohn and Sayed, 2008). Afghanistan has used two models – contracting out and in. In the former, NGOs operate under delivery contracts. In the latter, the MOPH contracts in managers to help strengthen services delivered using MOPH staff. The comparison models shows that contracting in provinces achieve greater improvements in maternal and child health coverage relative to contracting out provinces, but the absolute difference in improvements is small (World Bank, 2018b). The two contracting approaches also deliver similar results in terms of improvements in health systems performance. According to the World Bank report, the contracting out approach has performed well in insecure settings, due to NGO flexibility. However, Blaakman et al. (2013) found that the cost per BPHS outpatient visit was 58.5% higher in contracted-out provinces than in contracted-in provinces.

Alonge et al. (2015) compare different design of contracting out and in in Afghanistan, involving variations in budget flexibility, fixed or negotiable outputs, input or output-based payments and performance bonuses. They conclude that the contracting out arrangement which allows contractors to decide on how funds are allocated within a fixed lump sum budget with non-negotiable deliverables, and is actively managed through an independent government agency, is effective in improving equity of health services provision.

The widely portrayed success of the contracting model in Afghanistan is backed up by high official figures for health service

coverage but contrasts with evidence at household level, which suggests limited utilization of public health services, perceptions that these offer inferior quality, and a preference for private providers. The disconnection may be partly explained by under-estimated delivery costs: under-funded NGOs expected to provide health care to a whole contracted-out area managed to serve only a modest portion of its population. Despite ‘free care’, household out-of-pocket expenditure remains by far the largest source of health financing in Afghanistan, dwarfing all other funding sources, and capable of forcing poor households into catastrophic expenditure (Michael et al., 2013), although it has since been reducing.

Overall, experiences with contracting-out indicate that health service delivery can be considerably improved in a short time (Loevinsohn and Sayed, 2008; Soeters R and Griffiths F, 2003), and this model seems to have had particular resonance in in post-conflict situations (Blaakman et al., 2013; Palmer et al., 2006). Outstanding questions relate to the longer term impact of this approach and its cost-effectiveness – is contracting out by-passing weak public institutions or building capacity? How can it phase into longer term system strengthening? How cost effective is it in relation to alternative approaches? Jayasinghe (2009) also identifies some ethical issues related to contracting, including in FCAS settings, such as the need for accountability to the population, equity of access, sustainability and regulation of conflicts of interests.

Reflecting on the Cambodian experience, which now focused on contracting-in, Vong et al. (2018) also make some critical reflections, highlighting profound cultural and institutional constraints such as social

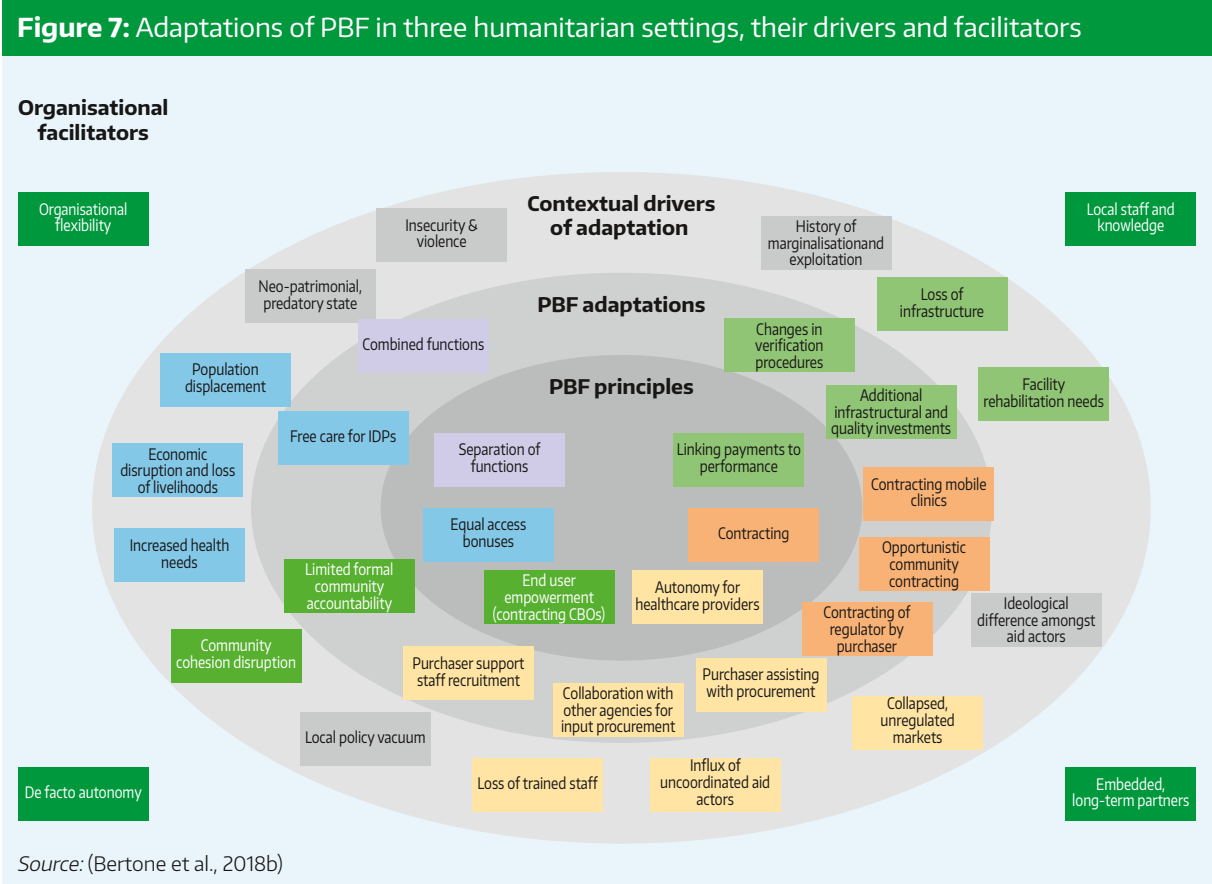
resistance to the involvement of non-state actors; limited willingness and/or capacity within the non-state sector to enter into contractual arrangements; bidding processes that may erode quality and favour local cronyism; and that performance based contracts may rule out informal providers who are often the most important source of health care for poor people.

PERFORMANCE-BASED FINANCING (PBF)

PBF – in which health facilities (largely) are paid according to the volume of verified and specific services that they produce, modified by quality scores – has been increasingly implemented in low and middle income

countries over the last decade. A recent literature review of PBF in FCAS settings (Bertone et al., 2018a) found that PBF is currently implemented in 23 FCAS, which are often the early implementers. Some FCAS features (e.g., greater role of external actors, greater openness to institutional reform, lower levels of trust within the public system and between government and donors) were found to favour contractual approaches. The review concludes that, rather than emerging despite fragility, conditions of fragility may favour PBF adoption.

Less clear are the effects of FCAS contexts and features on PBF implementation and on PBF effectiveness (Bertone et al., 2018a), which seems to be varied across settings



and indicators (see for example, on Rwanda (Basinga et al., 2011; Sekabaraga et al., 2011), DRC (Fox et al., 2014; Huillery and Seban, 2015; Soeters et al., 2011), Burundi (I Bonfrer et al., 2014; Igna Bonfrer et al., 2014; Falisse et al., 2014) and Chad (Kiendrébéogo et al., 2015)).

An analysis of PBF in three humanitarian contexts (South Kivu in DRC, Adamawa State in Nigeria and Central African Republic) points to the need for adaptation in design and implementation (instead of a “copy-and-paste” approach). Factors that may facilitate adaptation include organisational flexibility, local staff and knowledge, and embedded long-term partners (Bertone et al., 2018b).

PBF is often portrayed as a mechanism for strengthening strategic purchasing and improving efficiency and equity (Soucat et al., 2017). A recent study looked at the PBF’s effects on strategic purchasing in three FCAS settings (Zimbabwe, northern Uganda, and DRC) (Witter et al., 2018a). It concludes that these PBF programmes have not brought about systematic transformation of purchasing in the health sector, and some domains, particularly at government level and in relation to the population, have not been altered significantly. However, partial improvements are noted in some domains, such as creating more incentives for service delivery and quality for some services, while also bringing more focus to data quality and enabling national policies to improve equity (such as user fee removal or reduction) to be at least partially implemented. More generally, PBF has been a source of much-needed revenue at primary care level in under-funded health systems. The authors conclude that the evidence to date suggests that expectations of RBF bringing about widespread transformation in the sector should be nuanced and realistic. A

related political economy analysis of PBF in Zimbabwe highlights the importance of active local adaptation of financing policies, as well as the tension within PBF between supporting autonomy and exerting control (Witter et al., 2018b).

In Burundi, health financing reforms such as free healthcare for children under five and pregnant women and PBF are reported to have contributed to good governance in the health sector. The main contributions of these reforms to good governance were the separation of functions, transparency in management and a meticulous description of administrative procedures. Scrupulous monitoring resulted in several corrective measures. However, several unresolved questions remain, concerning the integration of vertical programmes and the sustainability of the system given the considerable costs (Peerenboom et al., 2014). Another study on the DRC concludes that while there may be a role for P4P in fragile contexts, to be effective it needs to be rooted in wider financing and human resource policy reforms (Fox et al., 2015).

ACCREDITATION AND REGULATION OF PROVIDERS

There is a general lack of published evidence on accreditation experiences and on how to effectively engage all providers, including non-state and informal providers in FCAS settings. There is some evidence from Liberia on the creation of an (externally led) accreditation system as part of the BPHS development to identify facilities that had the clinical and management standards to provide the BPHS (Cleveland et al., 2011).

Non-governmental and private healthcare providers have been incorporated into public

health systems (either by contracting or by informal arrangements) in order to increase geographical coverage of healthcare in a range of crisis-affected settings (Newbrander et al., 2011; Witter and Hunter, 2017c). There are two key challenges for this approach. First, governments in settings suffering protracted crises may have limited capability to manage and regulate such providers, leading to implementation problems and the undermining of state legitimacy. This has been reported in Afghanistan and DRC (Palmer et al., 2006; Waldman, 2006). Second, the growth of non-public providers may create sectoral distortions in health system resources, for example workforce migration to NGOs and private providers. Such distortions should be monitored and corrective responses introduced as needed (Pavignani, 2005).

The size and influence of civil society may be limited in crisis-affected settings as a legacy of crisis and by restrictive laws. In such settings, external support provides vital resources and training to develop the monitoring and advocacy roles of civil society. For example, civil society organisations in Uganda have received substantial international support, which has enabled them to campaign strongly for expansion of access to treatment for HIV in spite of a restrictive advocacy environment (Rosenquist et al., 2013).

BENEFITS PACKAGES

Most of the literature from FCAS settings on benefits packages has focused on documenting experiences of establishing essential health care packages, which are often contracted out to NGOs, as described above. There is also some, but limited literature, on approaches to regulation of providers and

specific considerations relating to health care provision during emergencies.

Given resource constraints, governments face difficult decisions on essential service packages. In conflict-affected settings, emergency packages typically focus on primary healthcare interventions relating to maternal, newborn and child health, immunisation, nutrition, mental health services and the diagnosis and treatment for some communicable and non-communicable diseases (Witter and Hunter, 2017a). Services for trauma and for sexual and gender-based violence are important in conflict-affected settings – for example, the emergency package in Liberia included counselling, treatment and referrals for survivors of sexual violence. Providers need to be adequately trained, resourced and incentivised to implement the chosen services, otherwise the package may have little resemblance to services actually provided. Those packages can then provide a basis for expansion of coverage (WHO, 2014).

Explicit basic packages of health services (BPHS) have been introduced post-conflict in countries such as Afghanistan, Liberia, South Sudan, Somalia, the Democratic Republic of Congo, and Cambodia. They are usually seen as helpful to provide clear policies and a sense of direction, address geographical inequities, and improve alignment of all providers (Eldon et al., 2008). Other potential advantages of the national roll out of a BPHS in a post-conflict setting may be rapid increases in healthcare coverage and standardisation of services, facilities, staffing, drugs and equipment (Ameli and Newbrander, 2008; Loevinsohn and Sayed, 2008; Petit et al., 2013; WHO, 2008), although there are concern about services which are not included in BPHS (Roberts et al., 2008).

After the fall of the Taliban in 2001, the Afghan transitional government and international donors found the health system near collapse. To begin activities that would quickly improve the health situation, the Ministry of Health (MOH) needed both a national package of health services and reliable data on the costs of providing those services (Newbrander, 2007). The objective of the BPHS was to provide a bare minimum of essential health services, which could be scaled up rapidly through contracting mechanisms with NGOs (Frost et al., 2016). The package, whose design was assisted by donor-funded technical assistance, had seven components: maternal and newborn health, child health and immunisation, nutrition, control of communicable diseases, mental health, disability and provision of essential drugs. Mental health and disability became second tier components, only implemented where financial and human resources permitted. The MOP agreed that the BPHS would be reviewed within two years to adjust the content of the package based on its effectiveness in addressing health needs (Newbrander et al., 2014). The cost of the BPHS was estimated at US\$4.55 per person in 2002 (Newbrander, 2007).

Afghanistan is the longest-running example of BPHS contracting in a conflict-affected setting and it is extensively documented (Howard et al., 2014). Its reported effects include that access to and utilisation of primary health care services in rural areas increased dramatically, the number of BPHS facilities more than doubled; access for women to basic health care improved; more deliveries were attended by skilled personnel; supply of essential medicines increased; and the health information system became more functional (Newbrander et al., 2014). The experience suggests that access to health services can be extended through contracting mechanisms in

a post-conflict state even in the presence of security problems (Ameli and Newbrander, 2008). However, other assessments are less positive. One finds that, despite the good intentions of the BPHS, not enough has been done to overcome the barriers to accessing its services and that overall service coverage remains low. High costs and the inability to afford treatment was the reason that 50% of Afghani survey respondents in 2004–5 gave for not seeking treatment. In 2004 almost 65% of the total expenditure on health in Afghanistan was incurred as out-of-pocket payments by households. This rose to between 72% and 79% of the total expenditure on health in 2006 (Frost et al., 2016).

In Liberia, as in other post-conflict countries, the recovery of the health sector was initiated through a Basic Package of Health Services (BPHS) approach. The government and partners, including international donors, contracted international and local NGOs to deliver the BPHS, as highlighted above. An analysis of the stakeholder perceptions finds that “health workers had a limited understanding of the BPHS and associated it with low salaries, difficult working conditions, and limited support from policy makers. Health workers responded by sub-optimal delivery of certain services (such as facility-based deliveries), parallel private services, and leaving their posts. These responses risk distorting and undermining the BPHS implementation. There were also clear differences in the perspectives of health workers and policy makers on the BPHS implementation. These findings suggest the need for greater dialogue between policy makers and health workers to improve understanding of the BPHS and recognition of the working conditions in order to help achieve the potential benefits of the BPHS in Liberia” (Petit et al., 2013).

SERVICE DELIVERY DURING EMERGENCIES

The traditional paradigm emphasized that health financing, governance and service delivery were likely to be operated independently of government during emergencies, with a large emphasis on operating through NGOs (Brinkerhoff, 2008; Newbrander et al., 2011), however, the emergence of more protracted and complex emergencies has reinforced the need for multiple strategies, utilizing and building more on indigenous capacities and systems and allowing for smoother entry and exit of international organisations. In Timor-Leste, international NGO efforts were initially critical to providing relief efforts to a traumatized population. However, later on, the cost of their support was seen as unsustainable and a hand-over plan was designed by local authorities. Since then, some NGOs have worked collaboratively with the Ministry of Health, showing that transition of NGO support from crisis to development is feasible within a national planning process (Alonso and Brugha, 2006; Mercer et al., 2014).

For IDPs or refugees in countries that have a more established health system and are not totally open to allow refugees to integrate into that, traditionally this has resulted in the creation of a parallel (externally funded, and free at the point of delivery) system for refugees, separate from that of the host communities. However, this has increased fragmentation and created challenges and disparities. Spiegel et al. (2018) argue that “the current modalities used to fund refugee emergencies are not sustainable and will worsen as health needs increase and health

services become more expensive, particularly in middle-income countries. New sources of funding and innovative financing instruments are needed”. They argue that the guiding approach should be that “ultimately, the goal is to integrate refugees into a host country’s functioning national health system, even when that system is delivering worse outcomes than the parallel system for refugees. However, if national health systems are not functioning or those systems are overwhelmed, particularly at the beginning of an acute emergency, then parallel systems may need to be established” (Spiegel et al., 2018). Direct contracts with private providers or national NGOs to cover health care costs of vulnerable households in contexts like the war in Syria have also been used by some international agencies recently, although evidence of effectiveness and costs is not yet available. The risk however is that humanitarian systems add to national health system fragmentation, as highlighted in Lebanon (Blanchet et al., 2016).

Promising recent examples of more integrated approaches in the region should also be examined and shared, including in countries which are not recognized as FCAS but host substantial displaced and refugee populations (and so are indirectly conflict-affected). For example, a current multi-donor programme is funding specific government health budget lines for poor uninsured host populations and refugees in Jordan, subject to external (to the Ministry of Health) but domestic verification (Montenegro Torres, 2018). This holds promise in that it uses existing funding and provision mechanisms and works through local institutions.

EFFECTIVE ENGAGEMENT IN HEALTH FINANCING AND HEALTH SYSTEMS ASSISTANCE

There is a very large literature on mechanisms to mobilise and coordinate external funding, and in particular those relevant to (and likely to be more effective in) the early recovery phase in FCAS settings. Many recommendations focus on ensuring that humanitarian assistance links effectively with more long-term development engagement and ensures long-term national institutional and health systems development is supported when setting up mechanisms for channelling humanitarian assistance (WHO, 2009).

The ‘Grand Bargain’ signed at the 2016 World Humanitarian Forum includes 51 commitments within nine themes: 1) Greater transparency; 2) More support and funding tools to local and national responders; 3) Increase the use and coordination of cash-based programming; 4) Reduce duplication and management costs with periodic functional reviews; 5) Improve joint and impartial needs assessments; 6) A participation revolution: include people receiving aid in making the decisions which affect their lives; 7) Increase collaborative humanitarian multi-year planning and funding; 8) Reduce the earmarking of donor contributions; and 9) Harmonize and simplify reporting requirements (IASC, 2016). The IASC Humanitarian Development Nexus Task Team has developed its own typology for engagement, which considers similar domains to Call 2011, linked to responsibility, capacity and security (IASC Humanitarian Development Nexus Task Team, n.d.).

Emergency and humanitarian settings present particular health and health system challenges, for which WHO has established procedures (WHO, 2013). WHO’s Protracted Emergency Framework (Draft, 2016) suggests the following objectives for the collective response to emergencies beyond the first 3-6 months (or where no shift to full recovery is foreseeable):

1. Progressively expand access, coverage and quality of an Essential Package of Health Services (EPHS) to populations at risk,
2. Progressively shift from a focus on service delivery by supporting health facilities to an area and population based approach through District Health Management (DHM) supported by community engagement;
3. Strengthen capacities to detect and respond to outbreaks of infectious diseases;
4. Strengthen capacities of MOH and health partners to prepare for, respond to and recover from emergencies arising from all hazards during the protracted emergency;
5. Use the health system analysis framework to identify priorities and opportunities for early recovery to connect with longer term health system recovery and reforms;
6. Strengthen national and subnational capacity for coordination of humanitarian partners and district health management, and creating links with development health partners;

7. Develop or update a health transition strategy that addresses humanitarian, recovery and development needs, and their interactions.

The framework also articulates the synergies between early recovery activities and longer term health system reconstruction approaches.

There are however risks to linking humanitarian work too closely with wider political objectives, such as state-building, and some highlight the importance of retaining principles of impartiality and focus on delivery of direct benefits to vulnerable people so as to avoid politicization and linked risks to health staff (Philips and Derderian, 2015).

While all donors have their own risk profile and approach to fragility, and each country context is unique, the most cited desirable attribute for support to post-conflict countries is flexibility (Manuel et al., 2012). A DFID paper also emphasizes the need for experimentation, supported by long-term commitment, good monitoring and evaluation, money, and above all dedicated staff (Leader and Colenso, 2005). Given the often fast-changing and volatile contexts, being able to respond in an agile manner is also important to effectiveness, whatever the sector. The focus is on finding best fit to context, more than necessarily what is seen internationally as 'best practice' (Ramalingam et al., 2014). Risks are likely to be higher and adaptive planning and budgeting are needed, along with a willingness to work across contested lines and to accept set-backs as well as successes.

Although individual case studies are often contested, with diverging views of their achievements and limitations, some general

principles emerge, including the need for a real but realistic role for the Ministry of Health, which is widely shared by all parties; strong donor coordination and alignment to reduce transaction costs and fragmentation; participatory decision making across actors and levels of the health system; focusing on results and performance monitoring of health-sector activities using multiple data sources; increasing the reliability of aid flows, ideally for sufficient periods to support system strengthening; and ensuring a critical mass of individuals with the right experience and expertise being deployed at the right time and able to look beyond agency mandates and priorities to support sector reform and results (Dalil et al., 2014). These have also been highlighted in reviews of global health initiatives operating in FCAS settings (Bornemisza et al., 2010; Pearson et al., 2014; Witter and Pavignani, 2016). Given the challenge of legitimacy and capacity, it is particularly important that health policies are not (nor seen as) externally devised (Gruber, 2009). A long-term presence is also likely to be needed, to provide space for the creation, sustenance, and maturation of institutions that are able to undergird the state (Chand and Coffman, 2008). It is also important, where legitimate authorities exist, to reinforce government stewardship and capacity (and avoiding bad practices, such as triggering brain drain and distortion through *per diems*) (Witter, 2012).

Much of the literature on development cooperation in FCAS settings – not specific to health financing or even health, but with pertinence to both – emphasizes the need to be more sensitive to the political economy of the situation (see Box 4). For example, a World Bank report on working in conflicted settings highlights the need for development partners to become better at diagnosing the

Box 4: What makes some fragile settings health financing 'innovators'?

A number of fragile and conflict-affected countries (and more specifically, post-conflict countries) have regularly featured in relation to health financing reforms. This is the case, for example, for Afghanistan (contracting, BPHS, trust fund arrangements, piloting of vouchers and demand-side financing mechanisms) (Loevinsohn and Sayed, 2008), Cambodia (contracting, performance-based financing, community health insurance, health equity funds, demand-side financing) (Ensor et al., 2017), Rwanda (performance-based financing, *mutuelles*, fiscal decentralization) (Sekabaraga et al., 2011) and Liberia (health pooled fund, contracting, BPHS, accreditation, performance-based financing) (Sondorp and Coolen, 2012). During the post-conflict phase, these countries appear to have been health financing 'innovators'. In these settings, health financing reforms have often been interrelated packages, adapted to their context and designed to work in complementarity with one another.

An important, though under-explored question, is why some countries (rather than others) have been multiple reformers and what are the driving factors of these reforms. One hypothesis relates to the existence of 'windows of opportunity' for reform in the post-conflict period due to the disruptive effects of conflict, the political energy released by the change of regime, the fluidity of the situation with new players and ideas entering the political arena, and increased funding available (Bertone et al., 2014; Kurtenbach, 2009; Pavignani and Colombo, 2009). However, this would not explain why some post-conflict countries are 'better innovators' compared to others. Additionally, there is little empirical evidence supporting this hypothesis, and some studies have shown that the immediate post-conflict period may not promote innovation as political uncertainty and fragmentation are unlikely to produce big, non-incremental change (Bertone et al., 2014; Pavignani, 2011; Witter et al., 2016a). The timing and feature of the peace process (for example, a prolonged transition or the sudden onset of peace) and the political settlements that emerged at the end of the conflict and the type of regime (the emergence of a stable and legitimate government, rather than continuing cycles of protracted fragility and conflict) may also play a significant role in explaining differences between countries (Witter et al., 2016a).

So far, few empirical studies have looked at this question and investigated the dynamics and the political economy of health financing reforms in relation to FCAS settings. The few case studies which do highlight the role of external actors, such as international donors and NGOs, in influencing policy-making processes not only in relation to funding (often related to geo-political considerations) and aid modalities that they bring, but also in terms of ideas and influence that they exert, especially in settings where governments are under-resourced and capacity is weak. This is highlighted with reference to Kosovo (Percival and Sondorp, 2010), Afghanistan (Robert, 2012), South Sudan (Cometto et al., 2010), as well as Sierra Leone (Bertone et al., 2018c). Recent research on the political economy of PBF introduction in Zimbabwe stressed the role of donors, but also showed how, despite the political and economic crisis, the retained managerial and professional capacity (a feature that distinguishes Zimbabwe from many other FCAS settings) allowed for more adaptation and contributed to created national ownership over time (Witter et al., 2018b).

real scope for progress, thinking and working more politically, tailoring interventions to different forms of violence, taking bargaining dynamics more seriously, realigning internal donor rules and incentives, and exploring new models of delivery and research (World Bank, 2017a).

Witter and Pavignani (2016) distinguish between different types of intervention in health systems, which may be appropriate in different contexts. The first two approaches are likely to be more common in FCAS settings, which is entirely legitimate if circumstances demand this.

1. Preventing systems under severe stress from collapsing makes their recovery easier and faster

2. Supporting is contingent: better performance lasts until inputs are discontinued
3. Strengthening equips the system to perform better on its own
4. Pursuing resilience and sustainability implies a longer, more sophisticated engagement

Given the demands of these ‘challenging operating environments’, they argue for a greater focus on systems for health, which link communities and informal systems with formal systems; for moving external engagement closer to service delivery levels, especially when conditions are varied across a polity and political blockages exist at national level; for more flexible and localized monitoring and assessment; and for more regional (cross-country) approaches where crises extend beyond borders.

GAPS IN KNOWLEDGE

The literature on health financing in fragile states focuses quite heavily on some countries – Afghanistan being by far the most highly documented – while others receive very little attention. Equally, some topics have received much more research attention than others, with aid coordination dominating, and some topics such as purchasing, quality of care, provider regulation, resource allocation, efficiency, and data and financial management systems are either totally or relatively neglected, perhaps because these are seen as less urgent issues in FCAS settings. They are however arguably equally or more critical to health financing and systems performance here.

It is also important to note the variable quality of studies reviewed, as noted previously in Witter (2012). Many are hampered by poor data quality, given the challenging settings (Woodward et al., 2016), and a significant proportion are conducted by designers and implementers of health financing reforms and are therefore not independent. Many are commissioned by external agencies and there is therefore likely a neglect of smaller, local and more home-grown reforms. The literature on fragile and post-conflict settings also tends to be distinct from that oriented towards humanitarian settings, mirroring organisational and funding differences.

Areas which would benefit from analysis in future, emerging from this review, include:

Resource raising and pooling:

- Empirical analysis of trends at country-level in aid and internal financing for

health in FCAS settings. What drives these trends over time? What are the consequences? How do they relate to the broader governance and political context (e.g., capacity to manage funds and coordinate donors)?

- Analysis of domestic resource mobilization which may be particularly suited to health in FCAS settings and financing incidence here more generally
- Assessment of ‘innovative’ financing tools such as social impact bonds and use of cash transfers for health-specific purposes

Purchasing:

- Documentation of reforms to strengthen and defragment health care purchasing arrangements in FCAS settings
- Understanding how to increase population engagement in priority setting and enforcing entitlements
- More documentation of experiences of joint purchasing for refugees, displaced populations and host communities

Benefits packages:

- Analysis of specific challenges for quality of care and approaches to managing them in FCAS settings
- Developing dynamic costing models to support service delivery in rapidly changing contexts
- Better understanding of the challenges and options for regulation of the mixed provider landscape in different FCAS settings

Cross cutting:

- Equity analysis of health coverage in FCAS settings specifically
- Analysis through case studies of how health financing design and implementation can convey social values and contribute to social resilience in FCAS settings
- Investigation of how to strengthen PFM and health financing data systems in FCAS settings
- Analysis of successful experiences in bridging humanitarian and development health financing modalities
- Analysis of the impact of health financing reforms on efficiency
- Understanding and managing the political economy of health financing reforms in FCAS settings
- Longitudinal studies of health financing institutional development and its determinants in FCAS settings
- Assessment of strategies to prevent and reduce corruption in FCAS settings

CONCLUSION AND FINAL REFLECTIONS

Our data analysis has shown that, as would be expected, FCAS countries have **significantly higher out of pocket expenditure, external dependency and health-related impoverishment** (using both thresholds). They also have **lower mean government expenditure on health** in relation to wider government expenditure and total health expenditure. However, much of this is driven by the tendency of FCAS to be low income; **when stratified, there are fewer clear difference at low income levels**, whereas external dependence and impoverishment remain significantly higher for upper-middle income FCAS, perhaps indicating the effects of shocks.

Conflict-affected countries within the FCAS grouping show similar patterns but more accentuated, with less external support and lower overall expenditure on health. **Chronic FCAS countries** (those in this category for more than five years) showed similar patterns to the wider group.

Trends analysis shows **some improvement in FCAS performance** on health financing indicators over recent years, but from generally lower starting points and with regional variations. In terms of **UHC coverage**, FCAS have **lower performance for all income levels**.

It is clear that there are substantial challenges for health financing in FCAS settings but also that considerable **ingenuity** has also been shown in addressing them, albeit often externally driven. It is also important to highlight that many models have been

developed and road-tested in FCAS settings – approaches like performance-based contracting and PBF emerged to a large extent out of the need to innovate in FCAS, and have since been applied in wider contexts. The literature highlights that crises often lead to innovation, and that innovations can leave a longer legacy (the issue of **path dependency**), which reinforces the need to use crises well.

In drawing conclusions, it is important to highlight again the **heterogeneity** of FCAS settings and the need to focus on each context as unique, with its particular challenges, opportunities and history. While there are some shared features, our analysis of overall datasets demonstrates the variation in performance on most health financing indicators, and also that many FCAS countries share features with low income countries generally.

Given this, the **guiding principles for health financing reforms** in support of universal health coverage (Kutzin et al., 2017) still apply in FCAS settings – in fact, even more so, given the greater severity of the challenges that they often face, such as fragmentation, complexity and volatility of funds, for example. However, their operationalization may need to be different and achieving them may take a longer or more staged journey – for example, moving from unregulated fees for service to flat fees, to increase predictability of payments, before gradually shifting more systematically away for out of pocket payments for core health services. Similarly, in some settings donors may be unable to work through government but can move toward better coordination with government to avoid fragmentation

and service gaps. Within Ministries, the development of project implementation units with semi-autonomy is arguably another such transitional mechanism, aiming to fill short term capacity gaps while offering a route to their longer term strengthening.

Given the regional nature of many conflicts and shocks, health financing analysis and support may be needed at **regional level** – for example in the EMRO region, where all countries are either directly or indirectly affected by conflict – as well as at national and **sub-national levels**. The focus should be on tailored strategies, which build on international learning but are closely contextualised and able to adapt. The only certainty is change, and building capacity to manage change is critical.

Although FCAS settings go through **different phases**, such as pre-crisis, reacting to crisis, stabilisation and recovery, many now face chronic problems and complex emergencies, in which **strategies for humanitarian response and development converge**. Lessons on contracting health care provision and insurance models are just some examples of areas where this convergence is occurring and can be further pursued. This is important to managing transitions.

Important messages emerging from this review include the following:

- All FCAS settings have health financing challenges but those which combine deficits in security, capacity and legitimacy are most extreme and require support which is adaptable, long term and politically astute.
- Political economy considerations are important in all settings but FCAS often require particular sensitivity, given the

underlying factors fuelling fragility, and typically include a larger role for external actors.

- Strategies in these areas need to be based on understanding the internal and external agency incentives, looking for politically feasible improvements, even where not optimal, and enabling work across politically contested areas.
- Many of the health financing challenges are linked to this configuration, with external actors adding to the fragmentation of policies and practices in many cases – hence the importance of coordination, even if direct relationships with governments are constrained.
- In some of these settings (e.g. acute crises or gradual collapse of functions), appropriate goals for health financing may be not so much advancing UHC but preventing loss of gains – for example, preventing a reversal of financial protection as budgets collapse and out of pocket payments replace them.
- Support needs to be tailored to regional, national and sub-national levels, including for specific vulnerable populations, such as refugees and other displaced people, who typically have higher health needs (such as mental health) and may have more limited entitlements and access.
- In chronic emergency settings where wider institutional structures exist, humanitarian and development assistance should aim to pool risks (e.g. through the local social insurance mechanism) and provide service coverage (e.g. through purchasing contracts with relevant providers) through these structures as far as possible, investing in longer term institutional capacity and avoiding parallel systems. During acute crises, this may not be possible but even in these settings distortions can be minimised.

- Recognising the importance of stable funding flows, more advocacy is needed for continued, predictable and (where possible) integrated external funding, with external partners refocusing their aid and support on those in most need globally.
- Further pooling of donor support, including harmonizing financial management, human resource and other procedures across donors, implementing agencies and districts, including through shadow alignment where needed, is recommended.
- Given higher levels of resource scarcity in many FCAS settings, coupled with high need, there is an even higher need than usual to focus resources on priority services (focused on vulnerable populations, with cost-effective services). The development of essential service packages is common in FCAS settings, and can form the basis for pooled funding by government and donors.
- In the context of underlying economic and social challenges, displacement and conflict and other crises, households' ability to access and pay for health care is typically reduced in FCAS settings, and attention to reducing financial and non-financial barriers is key; reports of reintroduction of fees in response to dwindling external support are concerning as populations are already bearing too high a burden in terms of out-of-pocket payments.
- The consensus on removing user fees in humanitarian crises is important in this context, but there are risks of difficult transitions when areas or populations emerge from acute crises, leading to loss of financial protection, coverage and health. Policies to extend protection and smooth transitions are important.
- There is an increased focus on cash transfers in general in development, however in the health sector unconditional cash transfers need to be combined with well-designed provider payments so that quality of care and appropriate care packages are offered (focused on those in need but also emphasising preventive health and public health measures). Unconditional cash transfers are more suited to addressing demand-side barriers, such as transport.
- Given the high likelihood of shocks, it is important to learn from the resilience literature on distributed capacity and plan health financing systems accordingly. Being better prepared for crisis may also include, for example, having basic packages established and costed, with draft contracts, so that governments and donors can react more quickly to shocks of various kinds; also having simple but functional systems for tracking expenditures and resource flows in the health system in place.

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ANNEX 1. APPROACH TO DEVELOPING THIS PAPER

An initial consultation on delivering health financing technical assistance in fragile and conflict-affected situations was organised by the WHO Health Financing Team in Geneva on 13th November 2017. The meeting brought together health financing focal points from AFRO and EMRO, the WHO Health Financing Team, and representatives from the Health Emergencies Programme and the Department of Service Delivery and Safety. External representatives included the UHC 2030 Working Group on “Support to countries with fragile or challenging operating environments technical”, Providing 4 Health (Health Financing Consortium), ReBUILD research consortium and the World Bank.

This meeting was followed by more in-depth consultation led by the WHO EMRO office in May 2018, focussed on health financing in chronic and acute emergencies. More than 30 participants attended, including WHO regional, head office and country level experts, representatives from other partners such as the Global Fund, Ministry of Health representatives from the region, academic experts and consultants specialising in health financing support in FCAS contexts.

The paper is based on the insights and experience of the authors, augmented by insights from the consultative meetings, quantitative data analysis and review of the literature, in which data from 168 published and grey documents were extracted.

REVIEW OF THE LITERATURE

LITERATURE SEARCH

A purposeful, non-systematic literature search was carried out with an iterative approach. We started from a general database search on PubMed and Scopus using the following key words: (“*conflict*” OR “*post-conflict*” OR “*reconstruction*” OR “*fragile*”) AND (“*financing*” OR “*systems*” OR “*performance*” OR “*research*” OR “*user fees*” OR “*exemptions*” OR “*budgeting*” OR “*equity*” OR “*access*” OR “*performance-based*” OR “*output-based*” OR “*pay for performance*” OR “*incentives*” OR “*resource allocation*” OR “*public expenditure*” OR “*contracting*” OR “*public/private*” OR “*global health initiatives*” OR “*aid*” OR “*funding*” OR “*budgeting*”) AND “*health*”. This resulted in 35,294 entries from PubMed and about 20,000 from Scopus. Since Scopus results can be ordered by relevance, only this result list was further considered and the first, most relevant 1,000 entries were screened (title first and abstract if necessary). As a result, a total of 85 documents were included based on a list of inclusion/exclusion criteria (see below), reviewed and relevant information and data from them were extracted.

As a second step, we focused our literature search on topics which were identified as particularly relevant and/or on which there were gaps in the documents. Additionally, targeted searches also included specialist journals and series (Conflict & Health, Disasters), institutional websites (ReBUILD, UHC 2013, WHO, WB, KIT) and suggestions from experts, as well as focusing specifically

on the ‘fragile’ countries⁵ for which no information had been yet retrieved. In total, 61 new documents were included and reviewed.

At the end of the literature search, a total of **168 documents** were identified, reviewed and included in the data extraction form.

Inclusion/exclusion criteria

Inclusion criteria were kept purposefully loose as our aim was to capture a vast range of issues and papers.

- Only documents referring to FCAS countries or multi-country papers including at least one FCAS are included. FCAS are broadly defined based on the WB harmonised list from the years 2007 to 2017 (Annex 3). Countries were considered FCAS for the purpose of the documentary review if included in the list for one year or more during the period. Additionally, other countries such as Rwanda, Pakistan, (northern) Uganda, Ukraine are also included because the countries (or areas within them) were considered fragile at the time when the research reported in the document was carried out.
- In contrast to the approach of the 2012 review (Witter, 2012), all documents referring to FCAS setting were included, both in the case they included a specific reference to the fragile/conflict/post-conflict situation and/or discussed the findings explicitly in relation to the FCAS setting, but also when they did not mention fragility/conflict explicitly or did so only in passing. A note of this was made

in the data extraction form.

- Again, in contrast to the 2012 review, documents referring to humanitarian responses, conflict period, emergencies and transition were also included.
- Only documents referring to at least one dimension/aspect of health financing (even in passing in a more general health system paper) were included. This means that documents referring to other HRH or information systems or other pillars were excluded.

DATA EXTRACTION

A data extraction matrix was prepared in advance (Table 12) which aimed to capture the broader information concerning the documents (authors, type of publication, country of reference, etc.). One of the information it aimed to capture were also the “main elements of health financing” to which the document referred to, as well as the specific “theme” which was discussed in the document. For both these categories, a pre-defined set of responses was prepared (Table 13) which later allowed for a comparison of the main financing elements and themes discussed across documents. Additional, open-ended entries referred to the “key findings” and the “findings in relation to fragility, conflict and post-conflict”.

Data and information were extracted from all 168 documents using this matrix.

DATA ANALYSIS

Bibliometric analysis was carried out to explore the document sources, year of publication, country/region of focus, as well as health financing element and theme described. Secondly, the data extraction matrix was analysed comparatively by looking at each

5 The definition of FCAS countries is based on the World Bank Harmonized List for 2007-2017 (see Annex 3).

Table 12: Main elements of the data extraction matrix

Author
Title
Publication type / Journal
Year
Source (Scopus, targeted searches, snowballing)
Research methods
Country/region
Main element of health financing (<i>see list below</i>)
Theme (<i>see list below</i>)
Key findings
Findings/comments/discussion linked to fragility, conflict, post-conflict setting (or no reference to it)
Relevant references / comments

“health financing element” and “theme” in turn (for example, “revenue raising/pooling – user fees exemptions” or “purchasing – contracting” or “health and state-building/peace”, and so on). In this way, information was collated and key findings charted across different documents in order to look for patterns, differences and similarities across countries and regions.

LIMITATIONS

We were purposefully broad in terms of inclusion criteria in order to be able to capture as much as possible of the ongoing debates. Additionally, the literature is vast and appears to have been growing over the last few years. Therefore, our literature search and review is not (and does not aim to be) systematic and we acknowledge that a number of documents may have been overlooked, despite several iterations in the search and expert advice. However, we believe it has captured the key debates and issues.

There were no checks in place or scoring system to assess the quality of the documents retrieved. Indeed, the quality of the research presented seemed to vary and documents include rigorous empirical research as well as descriptive viewpoint or editorial articles. Additionally, many of the documents were authored by researchers with some stake in the issue being presented (e.g., MoH or donor agencies’ staff, consultants, technical assistants, etc. presenting the results of a project/programme they were also directly implementing, managing, supervising or funding). When possible, this has been noted in the data extraction form.

QUANTITATIVE ANALYSIS

Based on the WHO data available (WHO, 2018), we examine associations of FCAS status with a range of health financing and health service coverage outcomes (Table 14).

Table 13: Predefined codes for “main element of health financing” and “theme”

Main element of health financing	Theme (→ sub-themes that are included)	
Revenue raising / pooling	Public spending → tax mobilisation level, progressiveness, govt allocation to health sector	Key features / challenges
	Private spending → (OOPS, catastrophic expenditures, informal payments, etc.	
	External aid → trends in aid levels, aid dependency, coping with too little or too much funding, aid coordination and effectiveness, influence of external actors	
	Tax revenue mobilization	Options for policy and practice
	Insurance / <i>mutuelles</i>	
	User fees exemptions and targeted exemptions	
	Health Equity Funds	
	Aid coordination mechanisms → Health Pooled Funds / Multi-donor Trust Funds / technical assistance / etc. + transitional funds	
Purchasing	Passive purchasing → fragmented purchasing, or no purchasing at all	Key features / challenges
	Efficiency	Options for policy and practice
	Contracting → contracting in, contracting out	
	PBF	
	Role of the private sector / non-state actors	
	Demand-side financing	
Benefit packages & service provision	Awareness of entitlements and entitlements not matching with provider payments (lack thereof)	Key features / challenges
	Regulation, especially of non-state providers (lack thereof)	Options for policy and practice
	BPHS	
	Regulating providers, accreditation systems, etc.	
	NGOs → role in service provision, coordination (or not) at local level, etc.	
Cross-cutting issues	Governance → Transparency and accountability, capacity of local institutions, legitimacy of the state, policy processes and windows of opportunity, path dependency	
	Health and state-building / health and peace	
	PFM → Fragmented PFM / cash flows and procurement done in parallel, input-based budgeting, lack of links between plans and expenditure, etc.	
	Equity	
	Humanitarian contexts → funding care for vulnerable groups, refugees, IDPs and migrants (user fees exemption, innovative mechanisms, etc.)	

Table 14: Summary of outcomes considered and year(s) of reference

Outcome	Year(s) of reference
GGEH % GGE	Average (2012-2014)*
GGHE-D % CHE	Average (2012-2014)
EXT % CHE	Average (2012-2014)
CHE % GDP	Average (2012-2014)
OOP % CHE	Average (2012-2014)
UHC index of essential service coverage	2015**
Catastrophic expenditures***	Last year available (varies for each country)
Impoverishing expenditures***	Last year available (varies for each country)

Note:

* last 3-year period available;

** only year available

*** Note that data for catastrophic and impoverishing expenditure is limited in availability, only available in specific countries in specific years. Additionally, the limitation for both of these data sources is that the FCAS status does not necessarily match up with the outcome data available. For consistency across outcome measures, we defined FCAS for the same country list as for all other outcome measures (see below), and compare the last available year of data for each individual country.

DEFINITION OF FCAS

We included in the analysis any country included in the World Bank's harmonized list (Annex 3) which was considered FCAS for at least one year over the 2012-2014 period.

We recognize that the FCAS definition is debatable and dynamic. Therefore, we also carried out the same analysis with two different definitions of FCAS: (i) including countries featuring in the FCAS list for more than 5 consecutive years in the 2007-2017 period, indicating chronic or protracted crises (see Annex 3, **fcas_chronic**) and (ii) including countries featured in groups A and B of the security dimension in OECD 2016 'States of fragility' report (i.e., extreme and high insecurity) (OECD, 2016), meant to represent a subset of countries affected by active conflict and severe violence (see Annex 3, **fcas_conflict2016**). We noted that the

results did not fundamentally change with the changing definition of FCAS, so that our analysis is relatively robust in terms of FCAS definition.

DATA ANALYSIS

We use bar charts to visualise the data across the FCAS countries for each outcome and compare to mean FCAS and mean non-FCAS values. We use t-tests to compare mean values for each outcome ((i) FCAS versus all non-FCAS countries available for each outcome measure) and highlight statistically significant differences. We further test FCAS versus non-FCAS:

- (ii) by income status (low, upper middle, lower middle, high income – (World Bank, 2018c)
- (iii) by WHO region.

ANNEX 2: DEFINING FRAGILITY

There has been a growing focus on fragile states since 2000, with a wide variety of interpretations of the concept by academics and international agencies. A systematic review of fragility and health, for example, shows an exponential growth of studies from 2001, apparently peaking in 2015 (Figure 8).

DEFINITIONS AND DRIVERS

There is no single agreed definition (Annex 2) but common elements across the definitions used include a focus on gaps in relation to three dimensions:

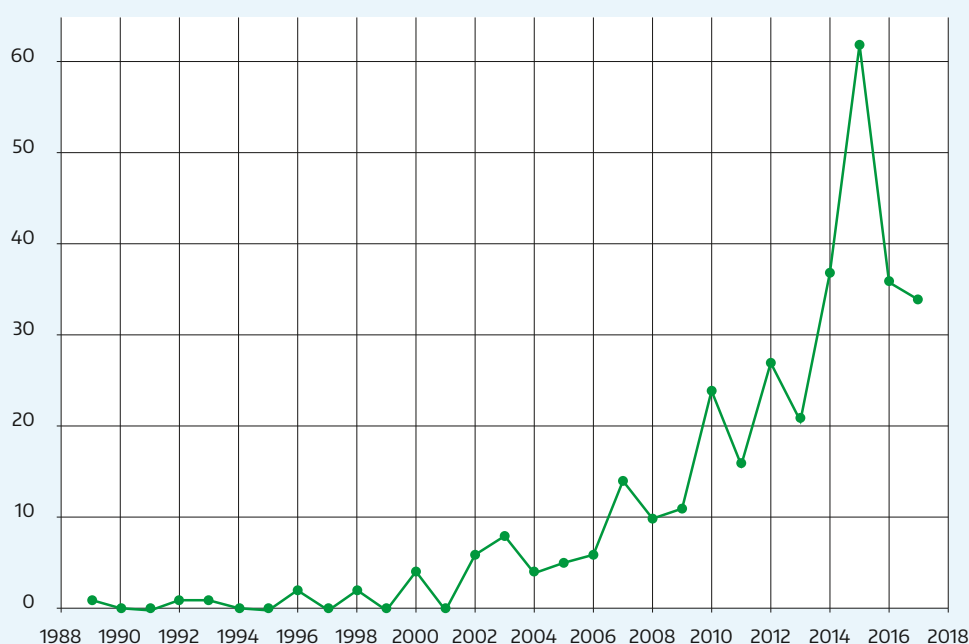
1. Government's **capacity and willingness to ensure provision of basic services** to its population (especially vulnerable groups).
2. Its **legitimacy**.

Its ability to provide **security and stability** (survival functions) (Witter et al., 2015).

CAPACITY AND WILLINGNESS

The health sector is most obviously affected by the first, service delivery-oriented domain, but the domains connect, in that in the absence of security and a trusted public authority,

Figure 8: Studies identified on fragility and health



Source: Diaconu et al, 2019

sustained and effective service delivery will not be possible.

The service delivery function includes wide-ranging components, such as effectiveness, capacity to execute policies, capacities in stewardship, coordination, and leadership, institutional capacity, and the achievement of equity of services across populations (Witter et al., 2015). Service provision is a highly political issue: by delivering services the state makes itself visible, strengthens its social contract and increases its legitimacy with its citizens (Eldon et al., 2008; Van de Walle and Scott, 2009). However, this is an area in need of research as available evidence about the causal relationship between service provision and state-building is limited (Ndaruhutse et al., 2012). McLaughlin (2012)

stresses how failure to deliver basic services such as security, health, education and justice is both a cause of fragility and a characteristic of fragile states. The consequences of fragility for service delivery are well documented and include inequitable coverage of services provided to populations, and breakdown of accountability (World Bank, 2004).

LEGITIMACY

Sources of legitimacy include: (i) performance/output legitimacy that can, for example, arise from effective and equitable service delivery (showing again how the domains connect); (ii) legitimacy derived from socially accepted beliefs about the rightful source of authority; (iii) input/process legitimacy, for example, from the constitutional rule of law and/or appropriate accountability mechanisms, and (iv) legitimacy based on international recognition and support (OECD, 2010, 2008). If a state can perform its core functions well, a virtuous circle may be created as

the delivery of certain functions reinforces citizens' confidence and trust in the state and therefore legitimacy, while at the same time legitimacy is necessary to manage state-society relations and deliver services (Ghani et al., 2005). The ten key functions identified are by this paper are: legitimate monopoly on the means of violence, administrative control, management of public finances, investment in human capital, delineation of citizen rights and duties, provision of infrastructure services, formation of the market, management of state's assets, international relations, and rule of law. The presence of a 'reasonably well functioning civil service' and the capacity of central and sub-national administrative structures is recognized as one of the essential elements of legitimacy and state-building by the OECD (OECD, 2008). The OECD highlights that the link between the presence of civil servants (such as health staff) and legitimacy of the state runs both ways: while the presence of capable civil servants is essential to ensure the functioning of public administration and service provision, their presence is not conceivable in the total absence of state legitimacy.

SECURITY

Conflict is a core characteristic of many fragile states (hence the use of the common acronym FCAS) as conflict undermines delivery of all three core domains whose absence constitutes fragility. Again, relationships run in both directions, as fragility may also lead to or predict conflicts – for example, in countries such as Syria, where legitimacy and authority was disputed, even though capacity to deliver services was high prior to the war. Chronic humanitarian crises, persistent social tensions, and violence or the legacy of armed conflict and civil war are highlighted by the IMF as common characteristics of fragility

(ILO, 2016). More recently, climate change pressures, such as natural resource scarcity, land use change, extreme weather events or volatile food prices, have become a recognized threat to stability too, particularly where government and institutions are already vulnerable (Rüttinger et al., 2015).

Poor economic performance is another contributory factor, as well as result of fragility. On the World Bank's 'Harmonised list of fragile situations' for 2017, only eight out of 52 fragile states are upper-middle income (and none high) (World Bank, 2017b). All others are low or lower-middle income. Moreover, for the 20 countries which remained on the fragile states list for the entire decade (2007-17), all are low income or lower-middle income (Annex 3).

The role of **institutional arrangements** is also highlighted by the literature on fragile states (OECD, 2016), as embodying and perhaps preserving the conditions of crisis: in economic terms, this could be institutions (importantly, property rights) that reinforce stagnation or low growth rates, or embody extreme inequality (in wealth, in access to land, in access to the means to make a living); in social terms institutions may embody extreme inequality or lack of access altogether to health or education; in political terms, institutions may entrench exclusionary coalitions in power (in ethnic, religious, or perhaps regional terms), or extreme factionalism or significantly fragmented security organisations. In fragile states, statutory institutional arrangements are vulnerable to challenges by rival institutional systems, be they derived from traditional authorities, from communities under conditions of stress that see little of the state (in terms of security, development or welfare), from warlords, or from other non-state power brokers. Whilst specifics vary across fragile

states, the underlying drivers can include a combination of ethnic fragmentation, neo-patrimonial politics, over-reliance of the economy on natural resources, conflict and corruption (Tayler, 2005).

There is a broad literature on the drivers of vulnerability and fragility, and a recent surge in interest in the notion of **resilience**, which can be conceptualised as opposed to fragility. While it remains contested, there is some convergence in the resilience literature on systems which are able to respond effectively to acute shocks, such as conflict, natural disasters or epidemics (Witter et al., 2017), or everyday stressors (Gilson et al., 2017). The absorptive, adaptive and transformative capacities which underlie resilience require legitimate and effective institutions (Blanchet et al., 2017), amongst other features.

TYOLOGIES

While the number of states or territories (for example, internationally unrecognised areas such as the West Bank and Gaza) varies from year to year, and list to list, the core group has been made up of 35-55 countries. 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 (Witter, 2012). 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 and Colombo, 2009).

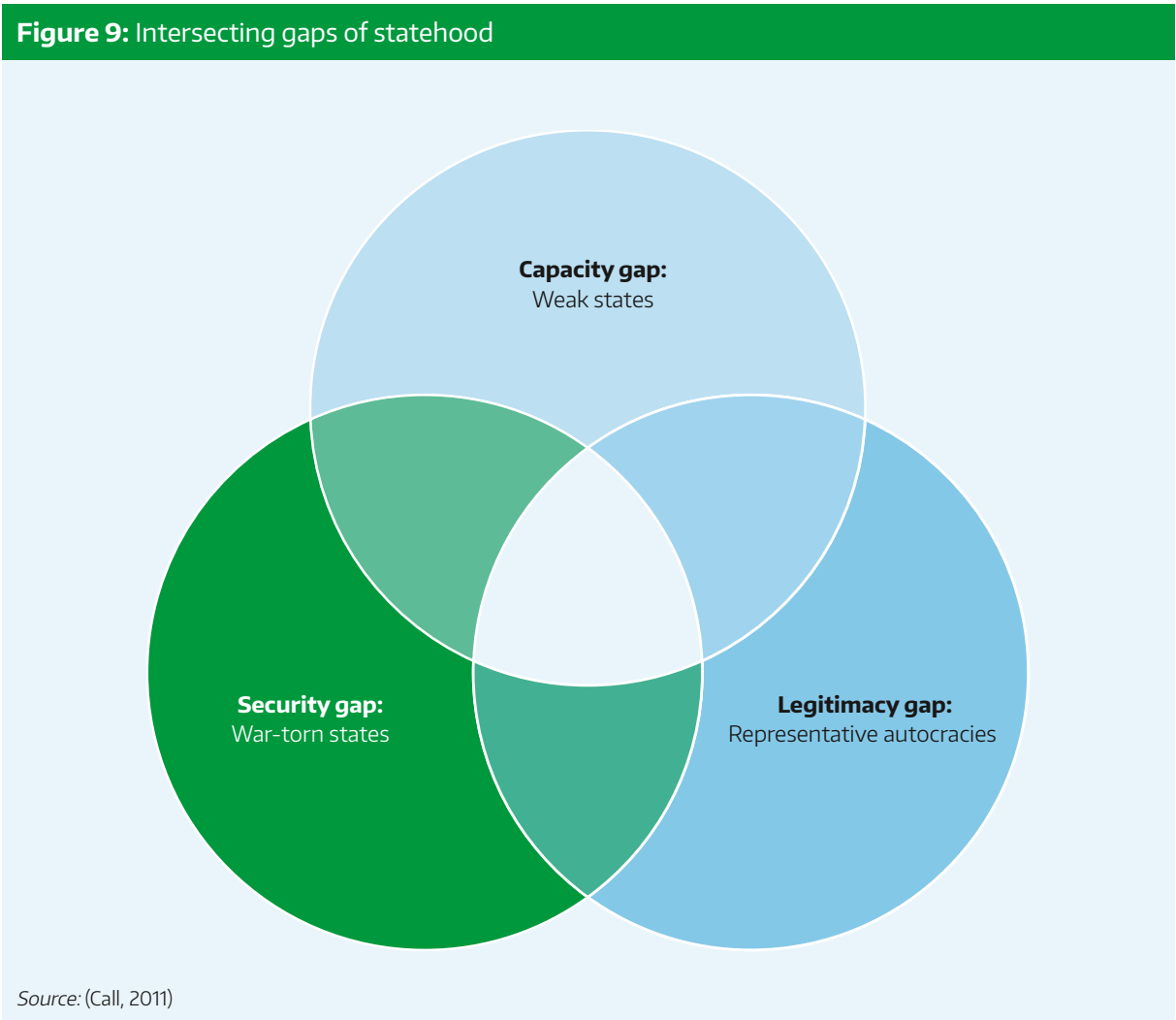
Analysis can also be focused on **regions** (regions with vulnerability to spill-overs of conflict and fragility from neighbours, for example in the Middle East at present) or on **sub-national levels**, recognising that within a fragile state there are often islands of stability, where recognised local authorities are providing essential services, including security.

Some studies have used proxy measures for each of the three domains and have classified countries according to which combination of gaps (legitimacy, security, capacity) they exhibit (Figure 9) (Call, 2011). Clearly those

countries with all three deficits face the most intractable challenges of fragility.

States of fragility are **dynamic**, although, as highlighted above, challenging the drivers of vulnerability can be challenging. One study which classified fragile states and tracked them found that 108 out of 131 countries did not change categories over 2000-2010 (Tikuisis et al., 2015).

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 (OECD, 2005). Others divide the post-conflict period into: 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).

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. Cambodia); or (4) deteriorating governance (e.g. Côte d'Ivoire). Each year the lists are revised, so fragility is a temporary status (AHSR, 2008).

The Global Fund has adopted the term '**challenging operating environments**' (COEs) (GFATM, 2016)

– a typology more focused on the operational challenges to engagement by external actors and therefore arguably less political. Countries in this typology are grouped into those facing acute instability, those facing chronic instability with weak health systems, and those facing chronic instability with stronger health systems (Pearson et al., 2014).

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 et al., 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 and Hoeffler, 2002). Poorer countries are more likely to be affected by conflict and are also more likely to relapse into conflict (Kruk et al., 2010a).

Pre-conflict is harder to assess but the 'fragile states index', produced by the Fund for Peace (The Fund for Peace, 2018), is one of the several attempts to do this, assessing vulnerability to collapse or conflict using 12 indicators – social (four), economic (two) and political (six). Using these, all recognized states are graded as sustainable, moderate (risk), warning or alert. Crisis Watch also provides regular updates on changes in conflicts and risk of conflict globally (International Crisis Group, 2018).

Other terms are used which substantially overlap with FCAS, such as 'disrupted' states or systems, protracted crises (Pavignani and Colombo, 2009), systems under stress and complex emergencies. **Complex emergencies** can be defined as situations where conflict or acute shocks co-occur with multiple additional, and often intractable, demographic, environmental, economic, and social instabilities. The term 'complex emergency,' though, is also used by humanitarian agencies to describe conflicts where the 'complexity' necessitates intervention by multiple agencies (The Robert S. Stauss Center, n.d.).

Although there is a group of countries that most observers would confidently classify as 'FCAS', there is a much greater number that demonstrate some, but not all of the characteristics of "fragility".

– The OECD (OECD 2016) assesses fragile or extremely fragile contexts using five dimensions (economic, environment, political, security, and societal). A context may be moderately fragile when it comes to security, but extremely fragile in political and societal aspects; 56 contexts are characterized by the OECD as either "extremely fragile" (high fragility in all

of the five dimensions noted above as well as widespread armed conflict or very significant levels of collective violence) or “fragile” (fragility in all of the five dimensions except low violence). In summary the OECD writes that states are fragile when its “...structures lack political will and/or capacity to provide the basic functions needed for poverty reduction, development, or safeguarding the security and human rights of their populations.”

- The World Bank (2018) has published the Harmonized List of Fragile Situations since 2011 with the 2018 list including 36 situations, from Afghanistan and Eritrea to DRC, Cote d’Ivoire, Kosovo and Myanmar; several countries with from sub-national conflicts, or other factors which affect fragility, are not on the list because they neither have a Country Policy and Institutional Assessment (CPIA) score below the cut-off (3.200) nor a peacekeeping or political/peace-building mission.
- The UK Aid Strategy (2015) provides a list of 54 fragile states, distinguishing between “high fragility” e.g. Afghanistan, Eritrea, and North Korea, “moderate fragility” eg. Angola, Azerbaijan, Kenya and Kyrgyzstan, and “low fragility” e.g. Djibouti, Cote d’Ivoire, Mauritania and Ukraine. In addition, ten countries, including Armenia, Jordan and Tanzania,

were listed as “neighbouring ‘high fragility’ states”.

- Though not conceptualised around fragility, WHO grades emergencies into three categories based on the extent, complexity and duration of organizational and or external support required. The grading of an emergency triggers WHO’s Emergency Response Procedures and emergency policies, and prompts all WHO offices at all levels to repurpose resources in order to provide support: http://www.who.int/hac/donorinfo/g3_contributions/en/
- The g7+ has embarked on its very own index for measuring state fragility, identifying five clusters (political legitimacy, justice, security, economic foundation, revenue and services), which are located on a fragility- ”spectrum” containing five stages. Main differences to other indices are constituted by privileged role of individual, state-specific characteristics and self- rather than external assessment. There are currently 20 member countries: Afghanistan, Burundi, Central African Republic, Chad, Comoros, Côte d’Ivoire, Democratic Republic of the Congo, Guinea, Guinea-Bissau, Haiti, Liberia, Papua New Guinea, São Tomé e Príncipe, Sierra Leone, Somalia, Solomon Islands, South Sudan, Timor-Leste, Togo and Yemen.

ANNEX 3: FCAS COUNTRIES LIST

Table 15: FCAS countries

	LICUS (low-income countries under stress)			Harmonized list of fragile situations								fcas_chronic*	fcas_conflict 2016**
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		
Afghanistan	severe	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	yes	yes
Angola	Core	core	core	Core	yes	Yes	yes					yes	
Bosnia & Herzegovina					yes	Yes	yes	yes	yes	yes		Yes	
Burundi	core	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	Yes	
Cameroon			marg	marg									
CAR	severe	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	Yes	Yes
Cambodia	marg	marg	marg										
Chad	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Comores	severe	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Congo Rep	core	core	core	Core	yes	yes	yes	yes				Yes	
Cote d'Ivoire	severe	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Djibouti	marg	marg	marg	marg							yes		
DRC	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Eritrea	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Gambia, The	marg	marg	marg	marg						yes	yes		
Georgia				Yes	yes	yes							
Guinea	core	core	core	Core	yes	yes	yes					Yes	
Guinea-Bissau	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Haiti	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Iraq					yes	yes	yes	yes	yes	yes	yes	Yes	Yes
Kiribati		marg	marg	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Kosovo	core	core	core	marg	yes	yes	yes	yes	yes	yes	yes	Yes	
Lao PDR	core	marg	marg										
Lebanon										yes	yes		
Liberia	severe	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	Yes	
Libya							yes	yes	yes	yes	yes	Yes	Yes
Madagascar								yes	yes	yes	yes		
Malawi								yes					
Mali								yes	yes	yes	yes		
Mauritania	marg												

Table 15: Contd.

	LICUS (low-income countries under stress)			Harmonized list of fragile situations								fcas_chronic*	fcas_conflict 2016**
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017		
Marshall Islands						Yes	yes	yes	yes	yes	yes	Yes	
Micronesia						Yes	yes	yes	yes	yes	yes	Yes	
Myanmar	severe	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	Yes	
Nigeria	marg												
Nepal					yes	Yes	yes	yes					
Pakistan													yes
Palestine (West Bank & Gaza)	severe	core	core	Core	yes	Yes	yes	yes	yes	yes	yes	Yes	
Papua New Guinea	marg	marg									yes		
Sao Tome and Principe	marg	core	core	Core	yes								
Sierra Leone	marg	marg	marg	marg	yes	yes	yes	yes	yes	yes	yes	Yes	
Solomon Islands	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	Yes	
Somalia	severe	core	core	Core	yes	yes	yes	yes	yes	yes	yes	yes	Yes
South Sudan							yes	yes	yes	yes	yes	yes	yes
Sudan	core	core	core	Core	yes	yes	yes	yes	yes	yes	yes	yes	Yes
Syria							yes	yes	yes	yes	yes	yes	Yes
Tajikistan			marg	marg	yes								
Timor Leste	core	core	core	core	yes	yes	yes	yes	yes	yes		Yes	
Togo	severe	core	core	core	yes	yes	yes	yes	yes	yes	yes	Yes	
Tonga	core	core	core	marg									
Tuvalu							yes	yes	yes	yes	yes		
Uzbekistan	core	core	marg										
Vanuatu	marg	marg											
Yemen			marg	marg	yes	yes	yes	yes	yes	yes	yes	Yes	Yes
Zimbabwe	severe	core	core	core	yes	yes	yes	yes	yes	yes	yes	Yes	
<i>Pakistan</i>	<i>Not included in WB's FCAS classification, but included in literature review as the country/areas are/were considered fragile or conflict-affected (Pakistan also included in the OECD classification, fcas_conflict2016).</i>												
<i>Rwanda</i>													
<i>Uganda (northern)</i>													
<i>Ukraine</i>													

Note: All countries included in the World Bank list (World Bank, 2017b) for at least one year in the 2007-2017 period are included in the literature review. The gray-shaded area indicates countries considered FCAS for the quantitative analysis (included in the FCAS list at least once between 2012 and 2014).

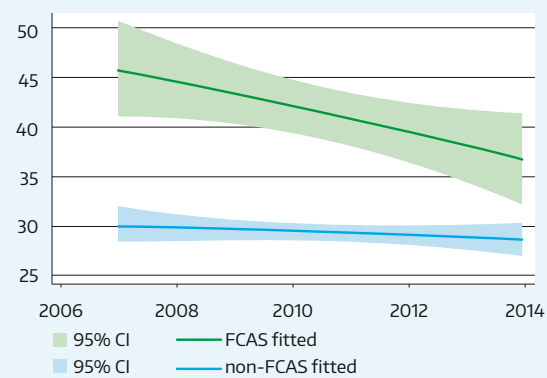
* Countries featuring in the list for 5 or more consecutive years in the 2007-2017 period

** Countries in groups A and B of the security dimension in OECD 2016 'States of fragility' report (OECD, 2016).

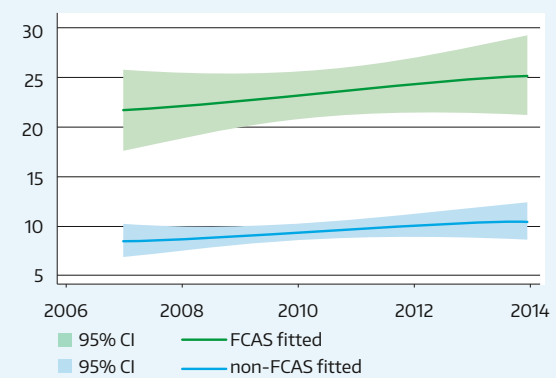
ANNEX 4: TREND ANALYSIS

PRIMARY ANALYSIS: COUNTRIES FROM HARMONISED LIST THAT ARE FCAS VERSUS ALL OTHERS

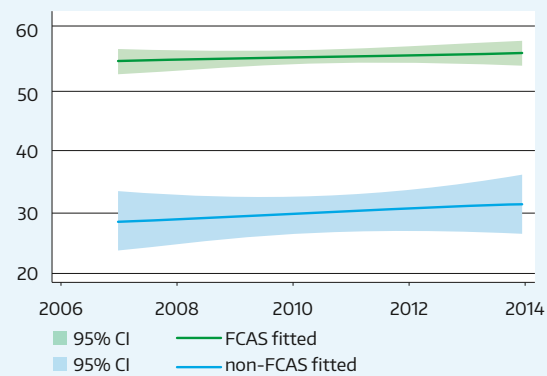
Household out-of-pocket payments as a % of total health expenditures



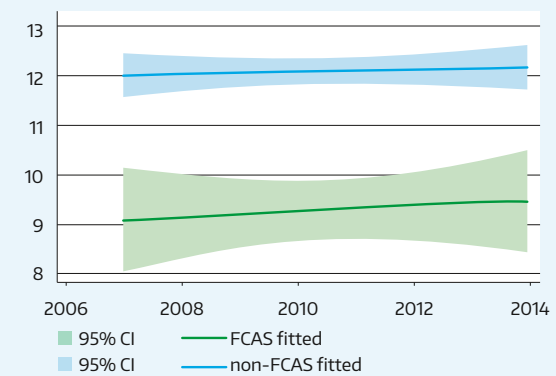
External funding as a % of total health expenditures



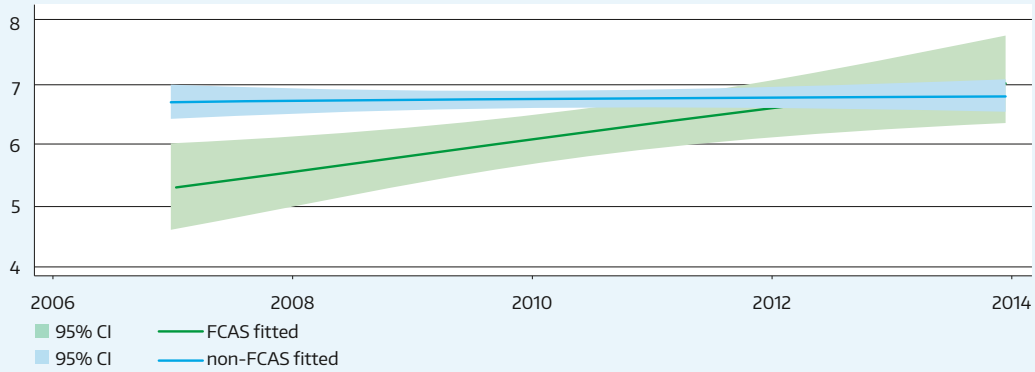
Domestic general government health expenditures as a % of total health expenditures



General government expenditure on health as a percentage of total government expenditure

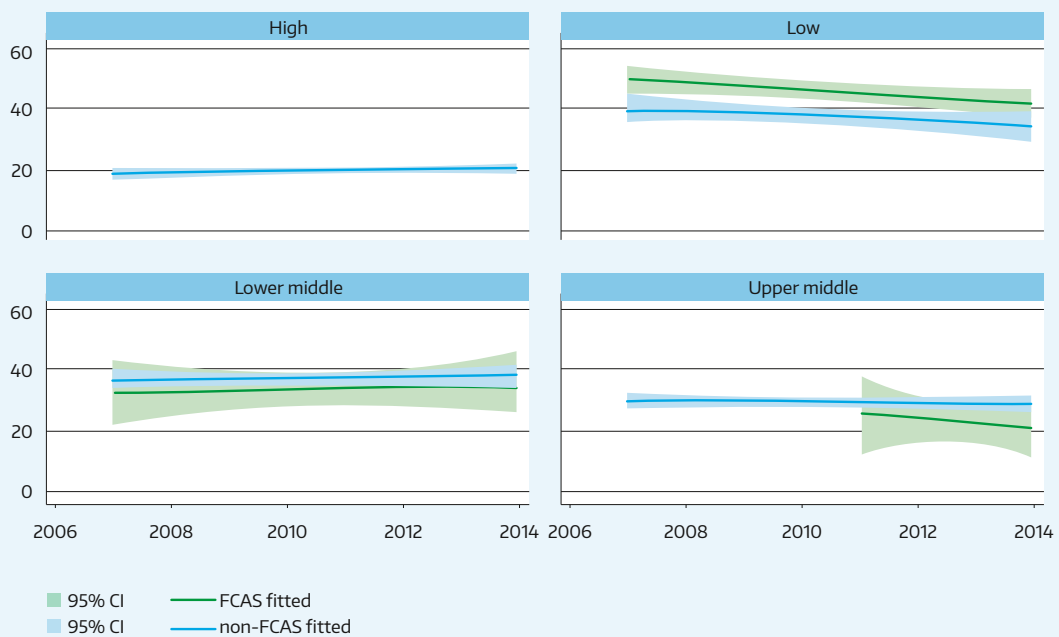


Total health expenditures as a % of GDP

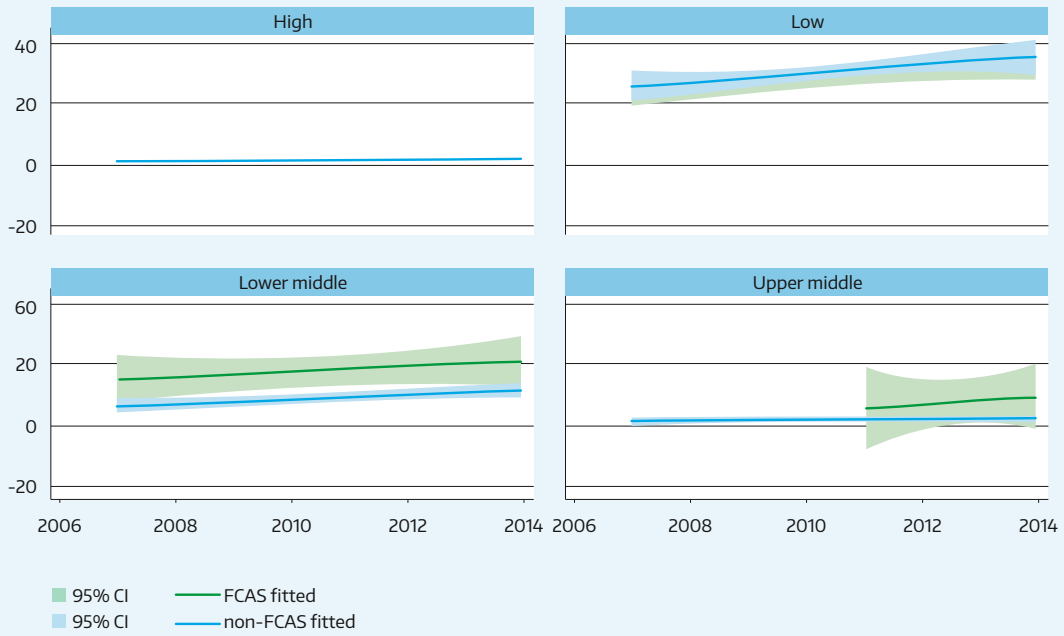


BY INCOME LEVEL (COUNTRIES FROM THE HARMONISED LIST THAT ARE FCAS VERSUS ALL OTHERS)

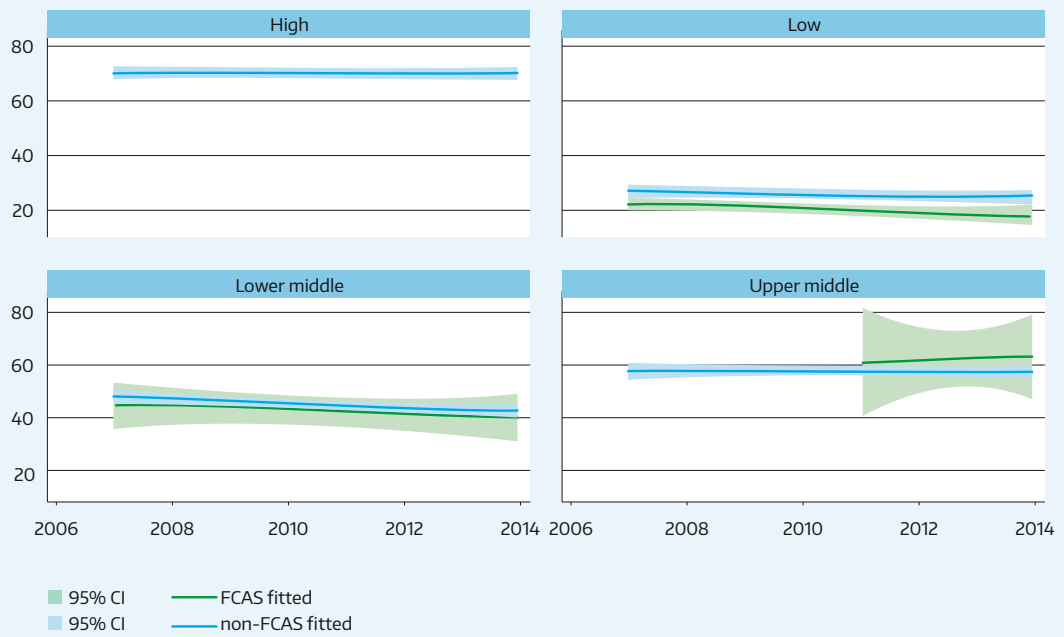
Household out-of-pocket payments as a % of total health expenditures



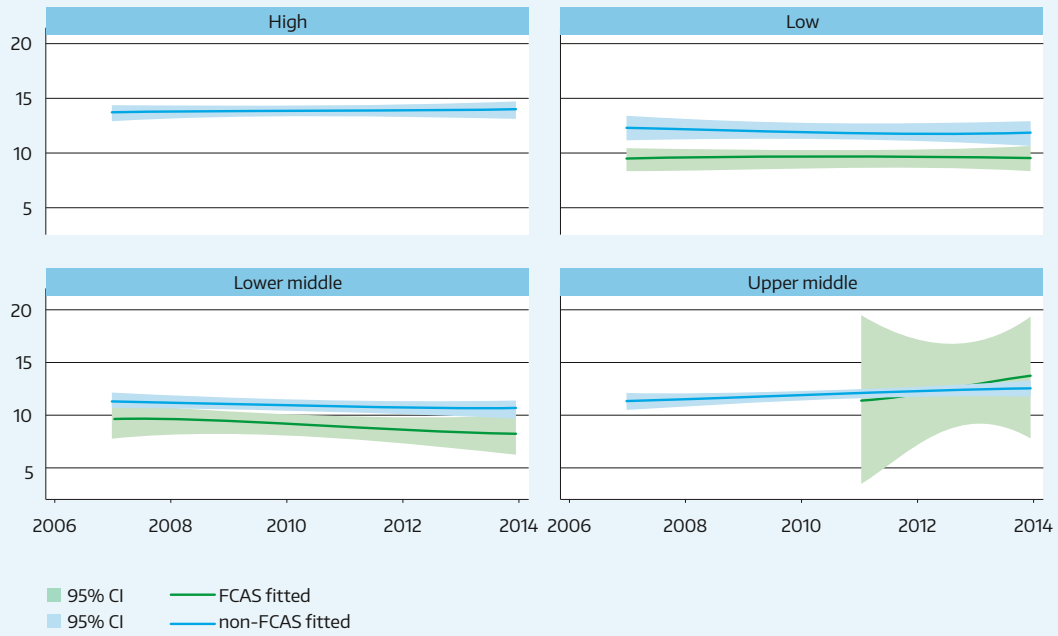
External funding as a % of total health expenditures



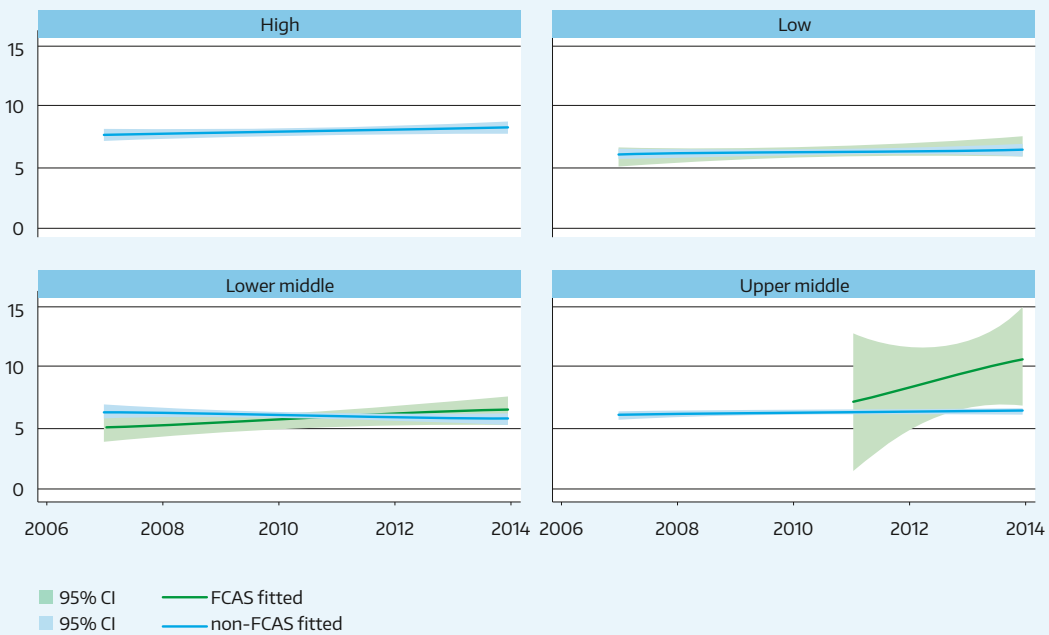
Domestic general government health expenditures as a % of total health expenditures



General government expenditure on health as a percentage of total government expenditure

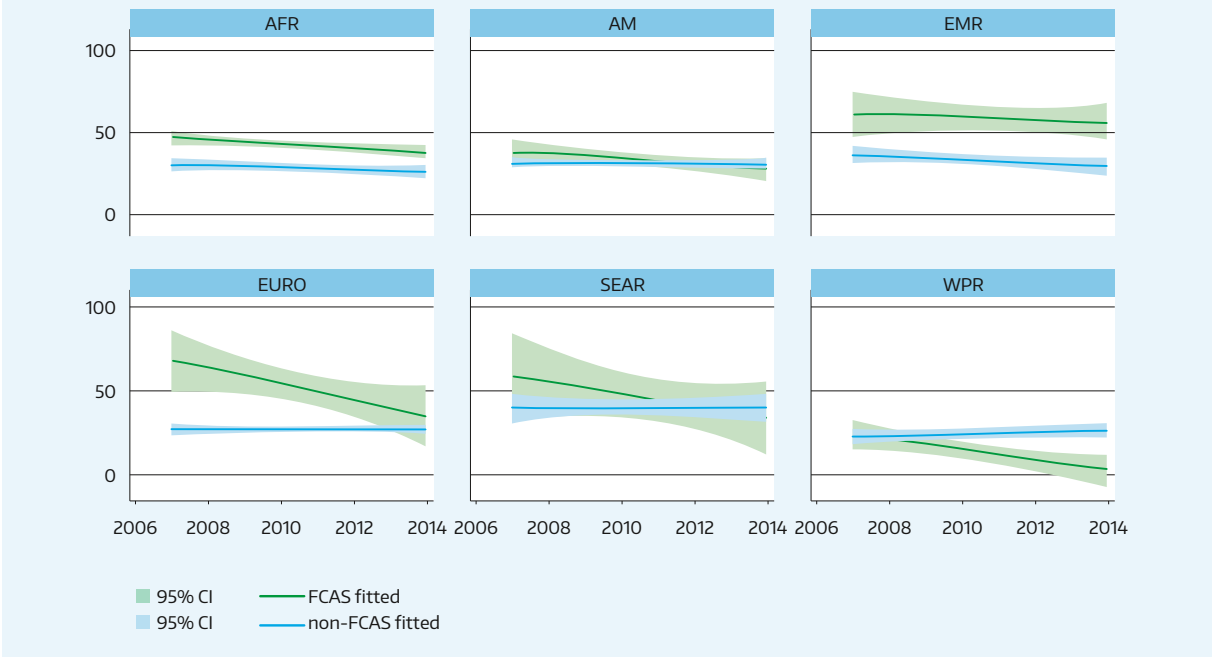


Total health expenditures as a % of GDP

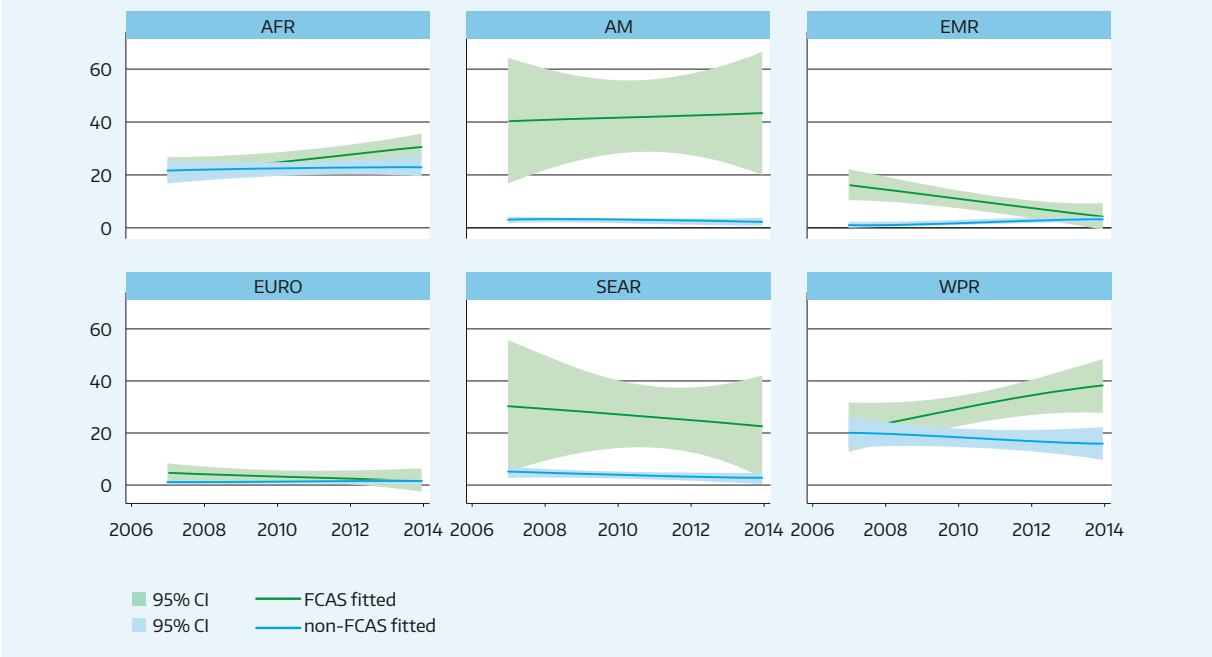


BY GEOGRAPHICAL REGION (COUNTRIES FROM HARMONISED LIST THAT ARE FCAS VERSUS ALL OTHERS)

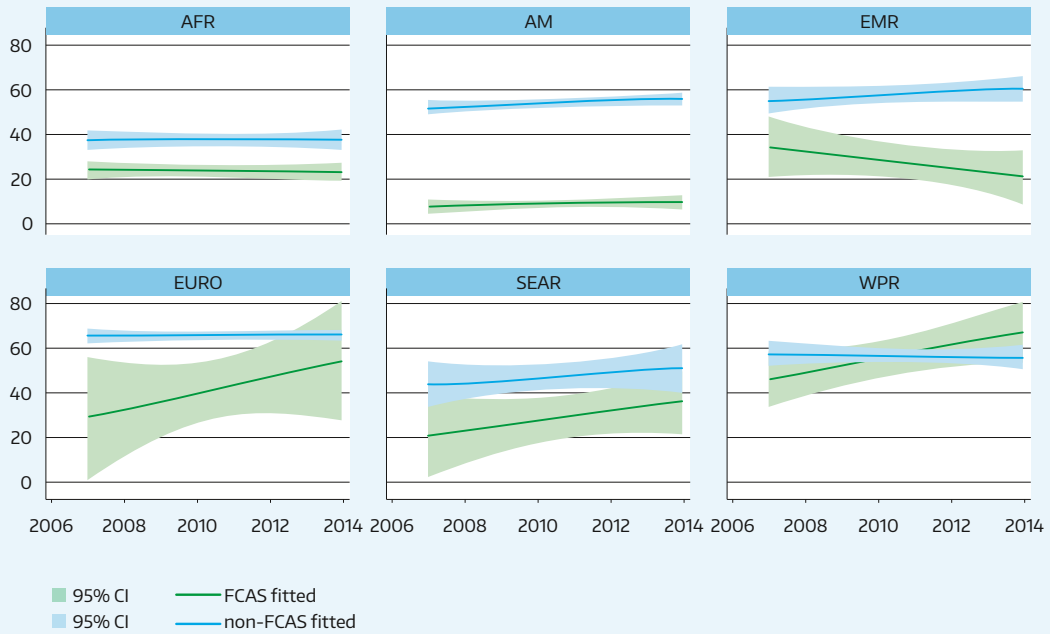
Household out-of-pocket payments as a % of total health expenditures



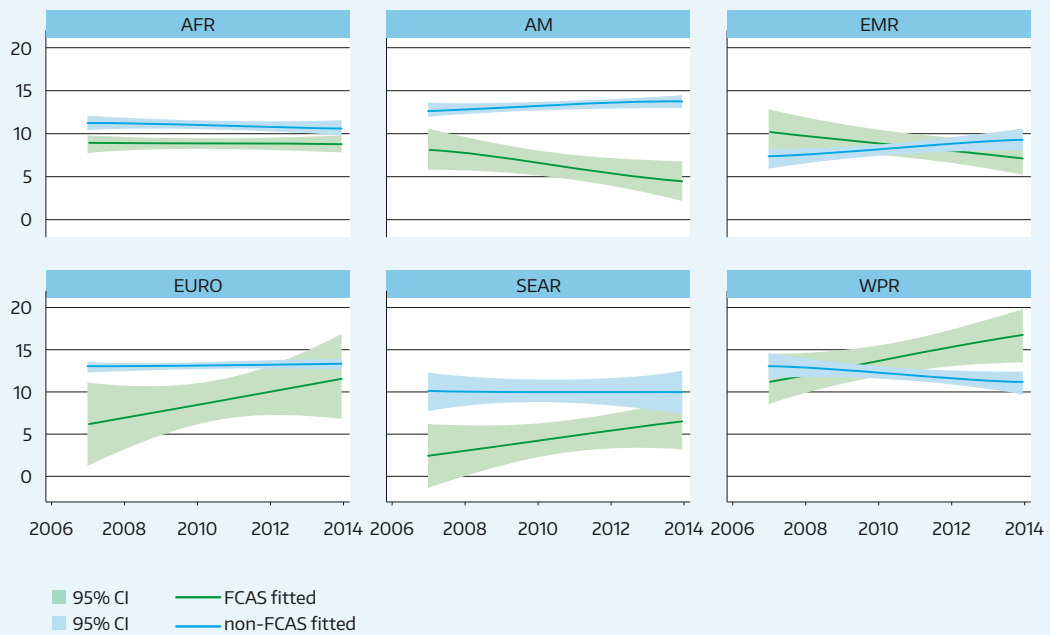
External funding as a % of total health expenditures



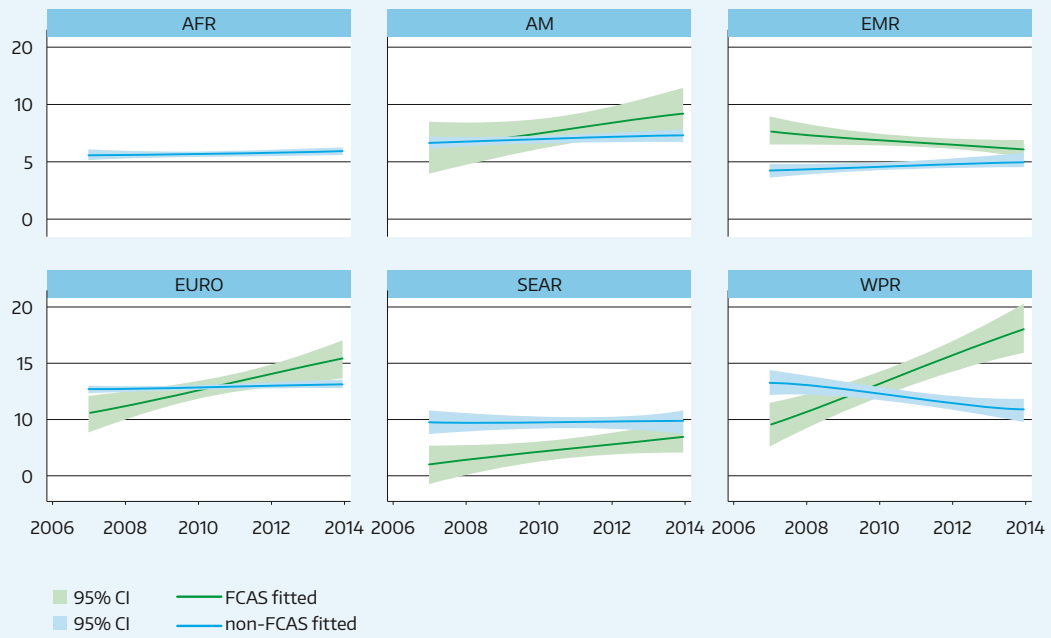
Domestic general government health expenditures as a % of total health expenditures



General government expenditure on health as a percentage of total government expenditure



Total health expenditures as a % of GDP





For additional information, please contact:

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