

HEALTH FINANCING POLICY & IMPLEMENTATION IN FRAGILE & CONFLICT-AFFECTED SETTINGS:

A SYNTHESIS OF EVIDENCE AND POLICY RECOMMENDATIONS

FINAL DRAFT



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World Health
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HEALTH FINANCING GUIDANCE NO 7

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(Health Financing Guidance Series No 7)

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Production: Phoenix Design Aid A/S, Denmark

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SUGGESTED CITATION

Jowett M., Dale E., Griekspoor A., Kabaniha G., Mataria A., Bertone M., Witter S. Health financing policy & implementation in fragile & conflict-affected settings: a synthesis of evidence and policy recommendations. Geneva: World Health Organization; 2019. Health Financing Guidance No 7. WHO/HIS/HGF/HFGuidance/19.7

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PROCESS AND ACKNOWLEDGEMENTS

This paper is the product of both a comprehensive review of both published and unpublished literature, and an extensive process of review and consultation. We extend our appreciation to the many comments we received on earlier versions of the paper at a number of events including: an initial agenda-setting meeting held at WHO Geneva in November 2017, an expert consultation meeting for the WHO EMRO region held in Cairo in May 2018, presentations at the Fifth Global Symposium on Health Systems Research held in Liverpool in October 2018, and a number of seminars held throughout March 2019: the UHC2030 TWG on UHC in Fragile Settings, an internal seminar of the WHO Department of Health Systems and Governance, the WHO JWT UHC and Emergencies Contact Group, and the Yemen MSP Review Seminar held in Annecy, France.

We are grateful for the guidance and detailed comments provided by Agnès Soucat (Health Systems Governance and Financing Department, Director) and Joseph Kutzin (Health Systems Governance and Financing Department, Coordinator). Inputs from Renee van de Weerd, Ben Lane, Helene Barroy, Inke Mathauer, Susan Sparkes, Elodie Ho, and Adelheid Marschang are also gratefully acknowledged.

Financial support was provided by the United Kingdom's Department for International Development (Making Country Health Systems Stronger programme).

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ABOUT THIS PAPER

- A significant challenge when writing this paper was the very wide definition used in institutional classifications to categorize states as fragile and conflict-affected. The range of countries included makes distinguishing a fragile state from a generally weak state difficult. This paper is not framed around institutional lists but rather uses a criteria-based approach focused on deficits in government capacity (see section 3.1).
- Fragility often occurs only in certain areas within a country, while other areas remain relatively unaffected, for example in north-east Nigeria at the time of writing. Throughout the paper we refer to fragile and conflict affected settings (FCAS), to reflect this reality. We give greater emphasis to settings where deficits are particularly significant.
- Within the broad categorization of FCAS, each setting varies considerably e.g. acute emergencies, chronic emergencies, large-scale population movements as refugees or internally-displaced, and conflict. Each setting has implications for policy recommendations. This paper does not address each specific setting but lays the foundation for more detailed analysis.

The motivation for the paper is to review existing health financing policy recommendations and consider whether, and if so how, these need revising given the challenging context of FCAS. The paper aims to inform policy i.e. the decisions and actions of those engaged in financing and delivering health services in FCAS, and its scope is limited to this agenda. We are particularly interested in the perspective of public policy given its central importance for the long-term development of health systems, and as such is closely linked to the humanitarian development nexus agenda, which tries to ensure better connectivity between humanitarian and development efforts as highlighted during the World Humanitarian Summit [1].

- Section 1 provides broader context, Section 2 summarizes WHO's general policy messages on health financing, and Section 3 looks more closely at definitions of fragility and overall health system challenges in FCAS. Section 4 describes the current situation in FCAS in terms of the health financing functions and draws heavily on a detailed literature review of the evidence and secondary data analysis commissioned from the ReBUILD Consortium, published separately as a WHO Health Financing Working Paper. Section 5 builds on Section 4 and develops specific recommendations for health financing policy development and implementation in FCAS.

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Key Messages

- **Extreme poverty, premature mortality, and ill health are increasingly concentrated in settings characterized by fragility and conflict (FCAS), often within otherwise stable countries.** FCAS are characterized by an increasing burden of disease, an increased risk of injuries and illnesses associated with violence, resurgent infectious diseases, mental health problems, and deteriorating food security. At the same time, household incomes tend to reduce, with a negative impact on coping strategies.
- **The extent of fragility and conflict can vary substantially within a country, and health financing solutions need to be adapted to reflect this.** Crises are often localized and dynamic, improving or deteriorating rapidly in the short-term. There may also be a deficit in a governments' political legitimacy as well as in its capacity to ensure security. These contextual differences within a country translate into greater complexity and diversity in revenue flows, from domestic, development and humanitarian sources. Adapting health financing solutions to this changing context is important, while remaining cognisant of the guiding principles for health financing policy.
- **As domestic public revenues fall, the capacity and in some cases willingness, of government to deliver essential services and ensure financial protection reduces.** Lower levels of prepayment and pooled funding in FCAS, and the increased reliance on out-of-pocket payments which results, is particularly problematic for universal health coverage (UHC). In turn, this creates a significant barrier to accessing services, and is a major reason why people postpone or forego health care in FCAS, despite increased health needs.
- **External funding for both humanitarian and development programmes plays a critical role in maintaining the public nature of funding for the health system, and in safeguarding the provision of essential personal health services, as well as population level interventions.** Ensuring that multiple new external sources of funds are pooled, or at a minimum well-coordinated, is essential to minimize fragmentation, duplication, and prevent unnecessary complexity in the health system. External funds should be channelled through and strengthen domestic public systems wherever possible; where not feasible, substitute mechanisms should be established which mirror public functions and build national institutions and processes. From the outset a vision should be in place for transition to domestic ownership.
- **Humanitarian funding can learn from development funding efforts to improve pooling and make purchasing more strategic, for example through contracting service provision.** In post-conflict settings, pooled development funds have used contracting to scale up service delivery and improve efficiency; furthermore, this approach has proved resilient where conflict has re-emerged. Initiatives to pool humanitarian funds (e.g. Common Humanitarian Funds, the first established in the DRC in 2006) are promising but could become more strategic, for example by contracting service provision during protracted conflict. Incremental measures, such as pooling humanitarian funds for centralized procurement, logistics and supply chain management, are important foundational measures.
- **Increased dependence on external funding brings with it influence over plans, policies and implementation capacity, which can be either supportive or undermining of local leadership, systems, and capacity.** In FCAS, increased dependence on external assistance has frequently contributed to fragmentation, duplication of services, dilution and distortion of limited human and financial resources, and weak coordination between levels of care. It can, however, also play a positive role for example by establishing mechanisms, for provider contracting as in Cambodia and Afghanistan.

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Key Messages contd.

- **Ensuring coordinated and coherent interventions across humanitarian actors, as well as between humanitarian and development operations, is critical both for short term effectiveness and for the development of a resilient health system in the longer term.** Decisions made during the humanitarian response phase can significantly impact the future pathway of a health system, a concern for the Humanitarian Development Nexus agenda. One issue to address is the current separation of the humanitarian and development responses, in terms of funding streams, operational modalities, and staffing, which does not reflect the dynamic nature of many settings (see Annex 2).
- **Financing disease surveillance, information systems, enforcement of health protection laws and regulations, planning and management of national strategies for health security, and other common goods for health is a priority in FCAS given the increased risks to health security.** As governments in FCAS often have significantly reduced fiscal capacity, external funding is critical in the continued provision of these core, population-based goods and related functions.
- **Where feasible, supporting core systems such as those required to pay salaries should take precedence over more complex payment methods.** While a guiding principle of health financing policy is to move away from input-based line item provider payment, in FCAS ensuring that basic inputs are in place should take priority. The increased influence of external actors frequently leads to experimentation with new health financing approaches, such as pay-for-performance (P4P). While these may bring much needed resources to front-line services, it is advisable to review the current approaches to its implementation in low- and middle-income countries, including FCAS, and consider how these can be adjusted to each context, weighting carefully risks and implementation costs, including verification approaches. Furthermore, P4P should be viewed as a complementary and not the main payment method.
- **While cash and voucher assistance (CVA) modalities can improve access to and the use of health services in humanitarian settings, supply-side support for service delivery is also required.** Unconditional or unrestricted cash transfers can help individuals to meet both health and non-health needs but should not inadvertently contribute to a fee-charging culture for priority services, which could pose a challenge for UHC in the longer run. CVA modalities should therefore be considered only as a complement to support for the supply of health services. Vouchers can improve equity in financing when they increase access to priority services for the vulnerable, and leverage improvements in the quality and efficiency of service delivery. With respect to the health sector, multipurpose cash transfers should ideally focus on covering the indirect costs of access (e.g. transport), while point-of-use fees are minimized or zero.
- **Where possible crisis-affected vulnerable population groups, such as refugees or the internally-displaced, should be incorporated into existing national health coverage schemes.** Furthermore, if a separate purchasing agency for health services exists, e.g. a health insurance agency, this should be used to purchase services for such populations to avoid creating new purchasing arrangements and hence avoid generating greater fragmentation in the way the health system is financed.

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1. THE BROADER CONTEXT

- **Approximately two billion people now live in states which are affected by fragility and conflict.** In 2015, fragile contexts were home to 514 million people living in extreme poverty and by 2030, without significant action, this number is expected to rise to 620 million people. As a result, approximately 80% of the world's poorest may be living in fragile contexts by that time [2]. Eighty percent of epidemics, half of deaths under the age of five, and more than one third of maternal deaths occur in situations characterized by fragility and conflict [3].
- **Out of twenty-two countries in WHO's Eastern Mediterranean Region (EMRO), nine are experiencing either an acute or protracted emergency [4].** Almost 30 million displaced people, more than half of all displaced persons globally, originate from the Eastern Mediterranean Region. In the WHO African Region (AFRO) there are currently ten humanitarian crises with significant public health consequences [5]. The Democratic Republic of the

Congo, the Syrian Arab Republic, and the Republic of Yemen continue to experience large and complex humanitarian crises¹.

- The increasing fragility being experienced globally, highlighted above, presents a serious challenge for progress towards universal health coverage (UHC). In light of, and in response to this evolving context, this paper reviews WHO's policy messages on health financing. Current policy messages build on the health systems framework, a functional approach to analysis based on revenue raising, pooling, purchasing and benefit design, and a set of core policy messages, signposts, and guiding principles.

1 A complex emergency can be defined as a humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from internal or external conflict, and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing UN country programme. See 6. UNHCR. *Coordination in Complex Emergencies*. 2001 [cited 2019 30 April 2019]; Available from: <https://www.unhcr.org/partners/partners/3ba88e7c6/coordination-complex-emergencies.html>.

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2. WHO'S GENERAL GUIDANCE ON HEALTH FINANCING POLICY IN SUPPORT OF UHC

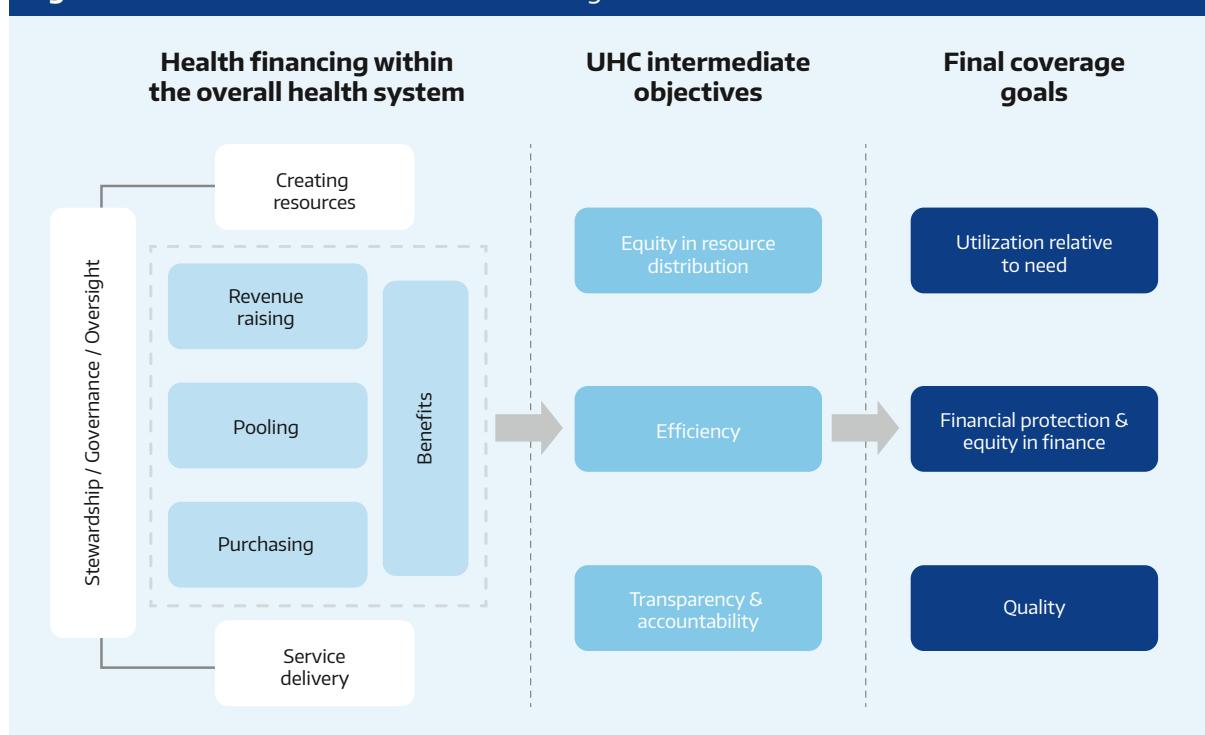
- **WHO's work on health financing builds on the World Health Report 2000 [7], which focuses on four key functions of a health system, one of which is health financing².** The health financing function is further unpacked into three subfunctions, namely revenue raising, pooling of funds, and purchasing of services, as well as policy on the design of benefits as show in Box 1 [9].
- **It is around these health financing subfunctions that policy is developed in all health systems, whether that system is labelled a tax-based system, a health insurance-based system or a mixed system.** WHO's recommendations around each of these subfunctions is guided by the health system objectives i.e. how can policies on revenue raising, pooling those revenues, and using them to purchase benefits, be designed in a way that contributes to progress towards UHC goals and, ultimately, improvements in population health (Fig. 1). Under Sustainable Development Goal 3, target 3.8 relates to UHC and is measured in terms of two indicators, 3.8.1 for service coverage i.e. utilization of essential health services³ [10], and 3.8.2 for financial protection measured in terms of those households suffering catastrophic health expenditures.
- **WHO has well-developed guidance for each of the health financing subfunctions, building on a set of guiding principles which draw on both normative thinking and empirical evidence** (see Box 1). The guiding principles focus heavily on the important role of government, particularly in terms of financing, to make progress towards UHC. Recommendations include taking measures to reduce fragmentation in the pooling of revenues, and to allocate these revenues to purchase services in a way which steers the health system in a more equitable, and efficient direction. The role of public institutions in facilitating financial arrangements, and in providing an appropriate and coherent incentive and regulatory environment across the health system is also central to UHC progress, a role which is often severely weakened in FCAS.

2 A subsequent WHO report unpacked these further into six building blocks one of which is health financing. 8. World Health Organization, *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action 2007*: Geneva.

3 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" 10. World Health Organization and The World Bank, *Tracking universal health coverage: 2017 global monitoring report*. 2017 Geneva..

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Figure 1: WHO's framework for health financing and UHC



Source: [11].

- The guiding principles have been translated into a set of detailed questions in the form of a **Health Financing Progress Matrix**, to facilitate an assessment of health financing policy at the country level [12]. The questions relate to core features of a health financing system which are of particular importance to make progress towards UHC, in that they represent or embody one of the guiding principles.

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Box 2: WHO's guiding principles and guideposts on health financing for UHC

a) Introduction

Health financing reforms cannot simply be imported from one country to another given the unique context of each country and its starting point in terms of health financing arrangements; the underlying causes of performance problems differ in each country and it is these causes which the reforms proposed in a health financing strategy must address. However, there are lessons from international experience that allow a number of guiding principles for reforms which support progress towards UHC, to be specified. These do not constitute a “how-to” guide, but rather a set of “signposts” that can be used to check whether reform strategies (and more importantly, reform implementation) create an appropriate incentive environment and hence are pointing and moving in the right direction in terms of objectives and goals in Figure 1. These principles, or signposts, are presented below for each of the health financing sub-functions and policy areas:

1) Revenue raising

- Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)
- Increase predictability in the level of public (and external) funding over a period of years
- Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

2) Pooling revenues

- Enhance the redistributive capacity of available prepaid funds
- Enable explicit complementarity of different funding sources
- Reduce fragmentation, duplication and overlap
- Simplify financial flows

3) Purchasing services

- Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination of both
- 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

4) Benefit design and rationing mechanisms

- Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)
- Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries
- Align promised benefits, or entitlements, with provider payment mechanisms

Source: [11]

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3. HEALTH, UHC AND HEALTH FINANCING IN FCAS

3.1. DEFINITIONS OF FRAGILITY

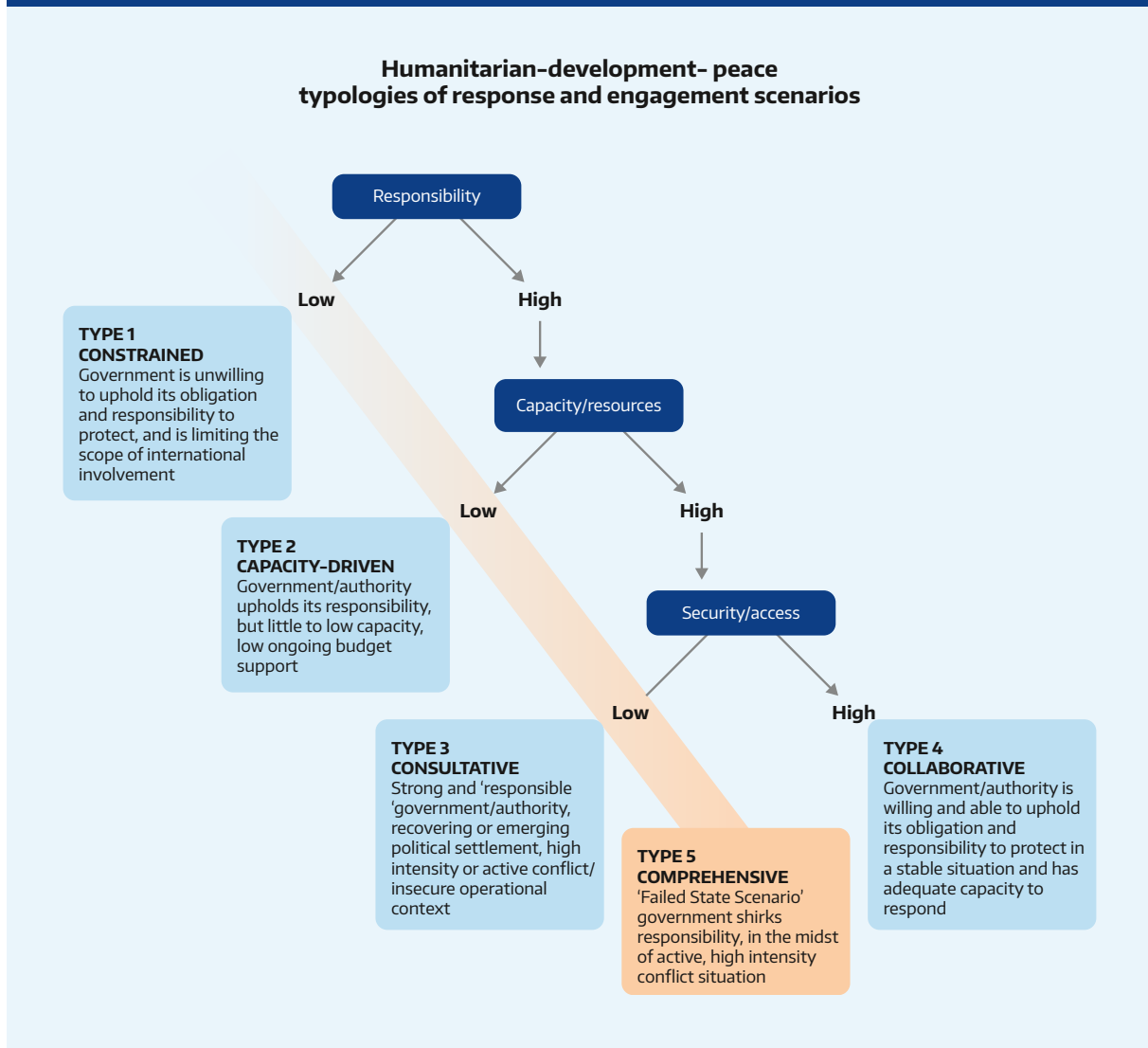
- **Fragility is a multidimensional concept, encompassing economic, environmental, political, societal and security criteria** [2]. It is an umbrella term, which covers very different settings which are fragile for different reasons. Based on these criteria, some broad lists include countries as different as Somalia, Pakistan, Nigeria and Solomon Islands.
- **For the purposes of this paper we follow the criteria-based of weaknesses or deficits in government capacities, two of which are of particular relevance** [13]. These include deficits in a government's capacity and willingness to ensure the provision of basic services to its population, especially vulnerable groups, and deficits in a government's ability to provide security and stability; these two deficits have clear implications for current health financing recommendations; the third deficit concerns the legitimacy of government in FCAS.
- **Countries with deficits across these criteria face the most intractable challenges of fragility**; Call [14] uses a proxy measure for these domains according to the combination of gaps they exhibit. Annex 1 summarizes formal or institutional classifications of fragile and conflict-affected states, or settings.
- **The deficits in government capacity approach provides a useful basis to review WHO's current health finan-**

cing policy recommendations. These recommendations are appropriate for many of the countries included in FCAS lists; it is, however, in countries displaying significant deficits in both capacities that entirely different modes of operationalization of health financing policy are often required or given greater prominence; this is where current recommendations on health financing policy are most likely to need revisiting. In general, this paper gives greater focus to such settings.

- **It is important to note that the degree of fragility may vary within a country, with multiple settings occurring simultaneously**, e.g. in Nigeria and DRC [15]. Within a state classified as FCAS there are often areas of stability where recognized authorities still provide essential services and maintain security. Analysis may also take a regional perspective e.g. spill-overs of conflict and fragility from one country to another. For these reasons we use the acronym FCAS to refer to "settings" rather than "states".
- **Fragile and conflict affected settings are often dynamic, progressing and regressing within relatively short time periods.** Attempts have been made to categorize stages of fragility, for example deterioration, collapsed, emergency, recovering, stabilizing, with movement forwards and backwards between these settings over time often observed. Annex 2 provides more information on attempts by a number of institutions to categorize

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Figure 2: Humanitarian-development-peace typologies of response and engagement scenarios



Source: [15]

different stages of fragility. In many settings, the situation is one of chronic problems and complex emergencies, in which strategies for humanitarian response and development start to converge.

- **The dynamic nature of fragility highlights the importance of the humanitarian development nexus**, which aims to break down the dichotomous approach to supporting emergency and

development settings, particularly by international agencies organized around separate funding streams, different interventions and operational modalities, and separate staff. The Humanitarian Development Nexus Task Team of the Inter-Agency Standing Committee (IASC) has developed a typology (see Fig. 2) to frame different scenarios [15], which captures many of the same criteria used in Call's diagram.

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3.2. UHC GOALS AND HEALTH SYSTEM CHALLENGES IN FCAS

3.2.1. FCAS AND UNIVERSAL HEALTH COVERAGE

- **FCAS are characterized by a rapidly changing burden of disease and increased risk of epidemics;** specifically, an increase in injuries and illnesses associated with violence is frequently observed, as is deteriorating food security, resurgent infectious diseases, mental health problems related to crisis, as well as the burden of chronic disease growing worldwide [16].
- **Given the disruption to service provision and financing commonly faced, the use of health services tends to fall in FCAS.** Data is only available at the national level, and the difference between states categorized as FCAS and non-FCAS are significant (43.4% as compared to 66.2%, $p<0.05$)⁴. However, coverage for essential health care (UHC index for 2015) shows a wide range of performance, from around 20% for Somalia to more than 60% in Iraq [10].
- **High reliance on out-of-pocket payments is particularly problematic for UHC, resulting from low levels of prepayment and pooled funding in FCAS.** Underlying factors include low trust in public institutions leading to the disruption and fragmentation of pooling mechanisms which may occur during conflict [18]. In humanitarian settings, an influx of refugees or internally displaced populations can add to the separation or segmentation of schemes with populations either covered or not covered by different agencies with varying mandates, resources and benefit entitlements.
- **While there are significant challenges regarding data on financial protection, on average fragile states have a significantly higher incidence of impoverishment due to out-of-pocket health spending** (1.64% as compared to 0.77%, $p<0.05$). However, the incidence varies from as low as 0.12% in DRC (at \$1.90-a-day poverty line), 0.58% in Afghanistan to 2.05% in Burundi and 2.98% in Cote d'Ivoire [10]. These figures should be viewed with caution however, given that financial protection may appear to be relatively good when service use is foregone, and household spending on health is low as a result. National averages can mask significant inequalities within a country, particularly for populations living in conflict affected areas.
- **A fall in publicly funded provision of health services, combined with reduced household ability to pay, tends to exacerbate existing inequities in service use:** analysis from Palestine suggests that with the exception of the primary-level, utilization of all levels of health care is significantly higher for the better-off [19], a finding common to other settings, but often more pronounced in FCAS.
- **In terms of demand for health services, expected out-of-pocket costs constitute a significant reason for people to postpone or forego health care in many FCAS settings despite increased health**

4 More details on the quantitative analysis are available in 17. Witter, S., et al., *Background note on health financing in fragile and conflict-affected settings*, in *Health financing working paper*. forthcoming: Geneva, Switzerland.

needs [20]. Meanwhile, certain FCAS settings are characterized by high levels of spending on medical care abroad, given health system challenges, which tends to be highly inequitable.

3.2.2. HEALTH SYSTEM CHALLENGES IN FCAS

- In FCAS government capacity, and in some cases willingness, to ensure provision of essential health services and public health functions can be severely limited, for example in terms of ensuring functioning laboratory networks, and early response and surveillance systems. Liberia was heavily affected by the Ebola epidemic (2014-2016), and while still considered fragile in the preceding years [21], access to services had been improving since the civil war ended; despite this, the country had very little capacity for emergency epidemiological surveillance and response, and for diagnostic testing, which contributed to the spread of the 2014 Ebola epidemic [22] [23]. Yemen was making steady progress to the health MDGs for example in term of maternal mortality, but this has faltered since the escalation of the conflict in 2016. Only 51% of health facilities are currently fully functional. The core platforms and

functions of the health system have been weakened due to the crisis, in part due to the brain drain of medical professionals, with many districts lacking doctors and specialists, and salaries not paid.

- A comprehensive review of health system characteristics in FCAS makes the following observations: limited capacity to provide health services to populations 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) to deliver health service effectively, much having 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; inadequate coordination, oversight and monitoring of health services; weak or absent processes to develop, establish and implement national health policies; non-operational health information systems for planning, management and disease surveillance; and inadequate public finance management capacity such as for budgeting, accounting and human resource management [24].

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4. THE HEALTH FINANCING SETTING IN FCAS

4.1. RAISING REVENUES AND POOLING: THE SETTING IN FCAS

- **FCAS are characterized by weaker fiscal capacity, as a result of lower economic growth rates, higher inflation, lower tax revenue to GDP ratios, larger government debt, and high dependence on official development assistance (ODA) [25].** 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 [26].
- **The gap left by low and or reducing domestic public spending tends to be replaced by household direct out-of-pocket spending, despite falling household income, and is often supported by family remittances from abroad, especially in countries with a large diaspora [27, 28].** One study on expenditure at private health providers in three zones of Somalia found that salaries and remittances were the main reported sources for families to finance health care, with 23.5% of households relying on remittances [29]. The increase in households out-of-pocket spending accompanied with the reduction in household's revenues results in an increased proportion of households facing financial hardship.
- **Countries defined as FCAS are associated with higher external funding as a proportion of current health expenditure (11% for non-FCAS and 19% for FCAS in lower middle-income countries; 3% for non-FCAS and 9% for FCAS in upper middle-income countries).** In post-conflict settings, there is also increasing reliance on external financing [30]. Indeed, external support may need to increase over time in order to support the expansion of service provision [13].
- **Even where there are efforts to pool numerous sources of external funding, funding for humanitarian and development activities still tend to flow and be managed separately from each other within the same country.** The Afghanistan Humanitarian Fund (HF) is a pooled funding mechanism established in 2014 specifically for humanitarian activities; NGOs can apply directly for funding [31]. Under the overall authority of the Humanitarian Coordinator (HC), it gives the HC greater ability to target funds to the most critical humanitarian needs, and enable efficient, rapid response to unforeseen events. However, there is no explicit coordination between the health projects supported through this Fund and the System Enhancement for Health Action in Transition (SEHAT) project financed through the Afghanistan Reconstruction Trust Fund [32].

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- **Increased dependence on external financing brings with it influence over plans, policies and implementation capacity, which can be either supportive or undermining of local leadership, systems, and capacity,** depending on the circumstances [33]. Financing tends to follow the agendas of funding agencies particularly where the local state is weak [34, 35]. As noted earlier, external funding tends to be separated into one stream for development assistance, and another for emergency/humanitarian response work, each with their respective staffing, policies, implementation arrangements etc. The Humanitarian Development Nexus agenda aims to mitigate the problems of fragmentation and incoherence which can result from this.
- A number of mechanisms have been employed to better coordinate external funds for longer term rehabilitation and development assistance. These include Multi Donor Trust Funds (MDTFs), the use of sector-wide approaches (SWAp) and ‘state-building contracts’ used by the EU [36]. Multi Donor Trust Funds (MDTF) have been the most commonly adopted approach in FCAS, including in Afghanistan and Sudan [37].
- **Country-Based Pooled Humanitarian Funds (CBPHFs) have been established in many countries to coordinate external funds for humanitarian responses.** CBPHFs provide a mechanism to allow the rapid allocation of resources in unpredictable or volatile contexts where priorities and programmatic focus shift rapidly and are multisectoral in nature. An essential feature is that funds are not earmarked and can be reallocated to interventions considered the highest

priority under Humanitarian Response Plans (HRPs) [38]. Flexible funding through CBPHFs gives partners the ability to innovate and tailor solutions to specific challenges.

- **In 2016 the Syria Humanitarian Fund, a CBPHF, supported the construction of underground “bunkerized” hospitals in besieged areas to protect patients and medical staff from airstrikes and shelling.** Another CBPHF, the Humanitarian Fund in Afghanistan, supported the implementation of eighteen health projects by fourteen partners focusing on a range of interventions including essential live-saving trauma care, rehabilitative care and psychosocial support, mobile outreach and scaled-up emergency obstetric and new-born care services [31]. However, there is often no explicit coordination between these investments and longer-term development programming.

4.2. PURCHASING HEALTH SERVICES: THE SETTING IN FCAS

- As domestic public revenues fall in FCAS, purchasing becomes increasingly **focused on salaries** [39], with higher level facilities such as hospitals often capturing a large part of these funds, leading to potentially greater misalignment with service delivery priorities. For example, in DRC the share of expenditure on human resources for health doubled from 42% in 2007 to more than 80% of government expenditures over 2009–2012, while the share allocated to operating expenditures 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, jumping again to 27% in 2013 [40].

- **Humanitarian funding is generally provided on a project basis with detailed input-based line item budgets**, and often go directly to international NGOs (INGOs), which support existing health providers to restore or maintain services through support for staff incentives, supplies and running costs. They may subcontract or partner with local NGOs to support service delivery. Country-Based Pooled Funds (CBPHFs) which are managed by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) country offices require detailed itemized budgets [41]. The same applies to the Central Emergency Response Fund (CERF) [42]. Organizations such as MSF which are exclusively privately funded provide direct funding to clinics and also operate on input-based line-item approach with strict rules about reimbursements. Humanitarian NGOs mostly provide direct support to the delivery of primary health care (PHC) services, while reimbursing other providers for referral services. Direct subsidies to cover the removal of user fees, and the cost of salaries (either full salary or top-up payments) are also common in settings where government is unable or unwilling to pay salaries [39].
- **Where there is a lack of confidence in government by external funders, preference for non-state actors, or a lack of capacity to deliver services, funds are often channelled directly to nongovernmental organizations (NGOs)**, which can increase effective coverage in the short term but carries the

risk of uneven provision e.g. where NGOs focus on limited geographical areas, and the implementation of interventions with unsustainably high costs. This pattern of service delivery is most common in post-conflict or post-crisis settings, such as Haiti, Cambodia, Afghanistan, Liberia and South Sudan.

- **Increased reliance on external revenues can drive greater fragmentation and incoherence in purchasing arrangements** for example, where externally funded NGOs directly pay for and often deliver health services. In DRC, for example, Provincial Health Authorities reported managing up to thirty contracts with externally funded organizations; in 2005, at least fifteen management units existed at the national level, each with its own administrative procedures and coordination mechanisms. In 2010 a district health management team in one province received multiple motorcycles from different partners who were responding to different national coordination and management units, while a neighbouring district had no means of transport for supervision [43]. Even with a single source of funding, separate coordinating mechanisms may be established for each project [43]. The increased influence of external actors can, however, drive the adoption of new approaches to provider payment e.g. performance-based funding, which can play a potentially positive role [44].
- **Where service provision needs to expand rapidly, for example in the post-conflict recovery period, and government lacks the capacity to respond in terms of infrastructure and human resources, contracting-out of health**

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services is frequently employed and supported with external development funding. Variants of this approach have also been used in limited parts of a country, for example where government lacks legitimacy or authority as in Afghanistan, Cambodia, the DRC, Liberia and South Sudan [13]. However, the extent to which this approach is appropriate or will work in the longer-term is unclear, especially when external funding decreases and where government ownership of this approach is limited. In addition, domestic processes to ensure the transparent award of contracts would need to be established, as well as local provider capacity to take up such contracts where previously external NGOs were involved.

- **In contexts with fragmented health financing arrangements, limited regulation by government, significant reliance on user fees, and a generally strained public sector, international agencies may find it necessary to directly contract with private providers or to provide cash to households.** Lebanon is an example. It has a fragmented and uncoordinated health care system, which is highly privatized [45, 46]. Vulnerable Lebanese citizens rely on public services financed through general taxes with widespread user fees but use of PHC services is limited and spending is concentrated on curative care. Palestinian refugees rely on external financing channelled through UNRWA with services provided through humanitarian agencies. UNHCR is responsible for the Syrian refugees, who rely on public services as well as some contracted NGOs and private providers [45].

- **Information on population needs and provider performance tends to be limited in FCAS, making the link between provider payment and needs, outputs or outcomes more challenging.** This is compounded by the way humanitarian funding flows, typically structured around projects with very short time horizons, ranging from a few months to a maximum of one year. Budget and expenditure data are often disconnected, with those teams managing staffing, procurement of medicines/supplies etc, separate from those working on delivering programme activities. This makes performance management very challenging. Between international actors, including development and humanitarian sectors, sharing of data and coordination of monitoring is often poor.
- **More generally, the capacity to regulate a pluralistic market of formal and informal, public and private (and hybrid) providers may be constrained by low government capacity and inadequate resources required for effective enforcement;** this can lead to variations in both the quality and content of services. While the national level may develop policy, these may be re-shaped both by implementation challenges and by informal practices; for example, INGOs in Sierra Leone, whose presence and distribution were the legacy of a crisis period, developed additional incentives beyond the official ones through the provision of equipment and medicines, and improvements to working environment. In particular access to medicines is a strong financial incentive for health workers if there is room for misappropriation and informal sale [47].

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4.3. BENEFIT ENTITLEMENTS AND CO-PAYMENT: THE SETTING IN FCAS

- **The very notion of a benefit entitlement is incongruous in many FCAS settings, although humanitarian agencies have for a number of years developed and provided minimum standards [48] for specific health services, such as the Minimum Initial Service Package (MISP) for reproductive services⁵.** In many settings these predefined packages are aspirational with access to services often dependent on personal and family resources, including remittances from overseas, contacts and networks [50]. While public or humanitarian policy may offer entitlements in theory, their realization is dependent on available funding and effective implementation. In the DRC a list of services to be provided at primary and secondary levels is defined nationally but does not correspond to effective entitlements for the population, which vary based on the external funding source and local preferences.
- **Increasingly, and in part driven by the increased involvement of external agencies, explicit basic packages of health services have been introduced in**

a number of FCAS. This is particularly the case in the post-conflict or reconstruction phase, and often goes hand-in-hand with a move to contract-out the delivery of services to NGOs. Examples of explicit entitlements can be found in Afghanistan, Liberia, South Sudan, Somalia, DRC and Cambodia. In some of these countries there are several development-oriented pooled mechanisms funding different entitlements, and in conflict settings there may be different packages implemented by humanitarian partners, with the scope and mix of services delivered determined by available funds, as well as operational and security constraints [51].

- **In Iran, registered refugees have similar entitlements as Iranian citizens.** This includes practically free access to PHC services, including antenatal care, family planning, vaccination and treatment for TB. In addition, UNHCR and government have assisted a large portion of the refugees (40% of registered refugees in 2011) to enrol into a health insurance scheme. UNHCR makes three different payments into the scheme: 1) a lump sum to reduce the overall premium for refugees (down to USD1.43/month in 2011); 2) the premiums of approximately 10-15% of those refugees who are considered vulnerable; and 3) part or all of the co-payments for vulnerable refugees [52, 53].
- **Out-of-pocket charges at the point of service use can constitute a significant barrier to accessing health services; even where basic health care services are officially free at the point of service other costs e.g. transport, may hinder access to services.** Over the past decade, many countries addressed these issues

5 The Minimum Initial Service Package (MISP) for reproductive health is a set of priority activities included in the SPHERE Handbook with a recommendation to implement at the onset of a humanitarian crisis, and later expanded into a more comprehensive package. These life-saving activities form the starting point for reproductive health programming to be sustained throughout protracted crises and the recovery period. For more information see the Inter-Agency Working Group on Reproductive Health in Crises 49. Inter-Agency Working Group on Reproductive Health in Crises. *The Minimum Initial Service Package (MISP) for reproductive health (RH)*, 2019 [cited 2019 30 April 2019]; Available from: <http://iaawg.net/areas-of-focus/misp/>.

by transitioning to free health services, with previous fee revenue replaced by increased prepaid revenues from government or external sources. These initiatives have been put in place for the entire population or for specific groups, such as pregnant women, children, and people with certain illnesses. Irrespective of official policies, however, in several countries (e.g. Guinea, CAR, Jordan, and DRC), direct patient payments at the point of delivery continue to be demanded from the most vulnerable groups, including refugees and displaced populations [54]. User fees are being (re)introduced in countries, including Afghanistan, having previously been removed to address financial barriers faced by patients [55].

4.4. CASH AND VOUCHER ASSISTANCE: THE SETTING IN FCAS

- **Cash and voucher assistance (CVA) has been used in both FCAS and non-FCAS settings to stimulate demand for specific services and to reduce financial barriers to accessing services, especially for reproductive care⁶. A number of types of CVA exist, and can be defined as conditional or unconditional, and as restricted or unrestricted⁷. 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 [57]. In Yemen, despite worsening conditions in 2014, a voucher intervention was able to channel funds to facilities at a time when funds flowing were highly erratic, enabling drug stock-outs to be addressed at the local level, and the delivery of critical maternal newborn health services for poor women and their families to be maintained [58]. However, there are preconditions for their effectiveness, including the availability and quality of services, and adequate capacity to manage a voucher scheme.

- **In Syria, 18,000 women received maternal and reproductive services through a voucher scheme. 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 services, improved staff and women's satisfaction and led to a reduction in turn-over of health professionals. The main challenges related to targeting the population most in need, controlling overbilling and unnecessary procedures, persistent security barriers and difficulties in accessing health facilities, difficulty in monitoring activity in private sector hospitals, and finding adequate financial resources [59].**
- **In Afghanistan, a conditional cash transfer (CCT) intervention in 2009-2011 was evaluated and found to be successful in stimulating demand for MCH services and increasing use of targeted services, in particular when both families and community health**

6 Conditional cash transfers refer to activities or obligations that must be fulfilled to receive assistance; in contrast, vouchers, or restricted cash transfers limit the use of the assistance received i.e. what a cash transfer can be spent on after the recipient receives it. See 56. World Health Organization and Global Health Cluster Cash Task Team, *Working paper for considering cash transfer programming for health in humanitarian contexts*. 2018: Geneva, Switzerland.

7 For more detail on types of cash-based interventions and their comparison, including voucher programming, see 56. Ibid.

workers were targeted [60]. However, there was also evidence of non-economic barriers to care which impeded women's access [61].

- **There is growing interest in and use of cash transfers in humanitarian contexts in particular multipurpose cash transfers (MPCT).** MPCTs are either a recurrent or single cash transfer to fully or partially cover a household's basic needs which include (but are not limited to) food security, livelihoods, shelter, water and sanitation, protection, health, nutrition and education [62]. While the volume of MPCT currently accounts for no more than 6% of total humanitarian assistance [63], there is currently a push to increase their use following commitments under the *Grand Bargain Agenda for Humanity*.⁸
- **However, being both unrestricted and unconditional, MPCTs do not specifically promote equitable access to health services. Health needs and related treatment costs are not distributed equally across the population which necessitates the pooling of risks through pre-paid revenue arrangements, particularly for high-cost care.** Furthermore, individuals may use cash for priorities other than health, and MPCTs have no direct potential to influence service quality, as can exist under voucher schemes with provider accreditation or competition. Many post-cash distribution surveys indicate that

households use MPCTs for health services as the second or third main use, despite a clear commitment under to ensure that essential services are provided free at the point of delivery [65].

4.5. PUBLIC FINANCIAL MANAGEMENT: THE SETTING IN FCAS

- **Weak domestic public financial management systems in FCAS, or a lack of trust by external funders in them, contribute to many of the challenges outlined above.** Critical bottlenecks in public financial management (PFM) systems include a weak budget formulation process, including an absence of budget proposals, excessive use of off-budget procedures, late approvals, weak execution, and overuse of exceptional procedures [66, 67]. Dependence on development partner's disbursements schedule and a lack of budget implementation tracking are also common in FCAS [68]. As with many of the challenges identified, these are not unique to FCAS settings but are often more extreme.
- **PFM systems are often highly fragmented in FCAS, with parallel cash flows and procurement systems driven in part by an increased reliance on external funders, NGOs etc.** This comprises a major source of inefficiency [69], in terms of ensuring that resources are used in a way which maximizes health gain; Porter et al [70] highlight how PFM systems in FCAS often develop asymmetrically, with formal aspects of modern systems layered with informal arrangements, and modern

8 Commitments under the Grand Bargain recommend that 'cash should be considered equally and systematically alongside other forms of humanitarian assistance, and where cash is considered feasible, it should be the preferred and default modality'. 64. The Agenda for Humanity, *The Grand Bargain – A Shared Commitment to Better Serve People in Need*. 2016: Istanbul, Turkey.

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PFM mechanisms applied only to a small part of the revenue sources.

- **In post-conflict settings a number of countries have relied heavily on external capacity to substitute for PFM capacity deficits** [71]. A key difference compared to approaches in non-fragile environments is the fact that capacity substitution and supplementation (donor-paid staff in line positions and use of top-ups) have been used to a significant extent in many post-conflict environments. PFM is often given priority in the early recovery period given its importance in strengthening capacity,

transparency and accountability, and as a result driving future support from bilateral and multilateral external funders. Afghanistan, Kosovo, Liberia, and Sierra Leone, have made significant progress in PFM reforms and have relied on extensive capacity substitution in the short-term [71]. These reforms can contribute to the institution-building objectives and contribute to regular payment of salaries of civil servants. However, the reliance on external support poses a challenge for longer-term sustainability, particularly in the lower-income countries.

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5. REFLECTIONS ON HEALTH FINANCING POLICY AND IMPLEMENTATION IN FCAS

5.1. REVENUE RAISING AND POOLING IN FCAS: POLICY CONSIDERATIONS

- **Given reduced fiscal capacity in many FCAS, or the unwillingness of government to invest in affected areas, external funding for both humanitarian and development programmes plays a critical role in maintaining the public nature of funding for health services**, which in turn is critical to protect access to essential services. At the same time, efforts to maintain domestic revenue raising capacity is important as an investment in state-building, for the resilience of the health system, and for its longer-term progress towards UHC [72].
- **Coordinating the flow and use of external funds is a priority given their increased significance and in FCAS.** Both CBPHFs and MDTFs significantly improve the coordination of external funds and have been pivotal in minimizing fragmentation, duplication, and preventing unnecessary complexity in the health system. However, from the Humanitarian Development Nexus perspective and the longer-term development of the health system, it is important that the processes and policies inherent in these two vehicles are harmonized both with each other, and with existing government systems.
- **Under certain circumstances international rules may prohibit the direct**

financing of governments [73]. As a result, there is often a greater emphasis on coordinating with, rather than working through government channels [74], particularly when the capacity or authority of government, or indeed trust, is considered to be low. Fragmented authority within government in FCAS can also seriously hinder the political dialogue necessary with external funders to increase budgetary support [75].

- **Shared sovereignty over public funds between the re-emerging state and external funders can lock in PFM systems improvements but requires careful exit planning to ensure sustainability** [71]. In some post-conflict countries such as Kosovo and Liberia, joint sovereignty over public funding for services was important for the legitimacy of the state; incentives to maintain a close relationship with the international community were also strong. Such temporary arrangements can offer a win-win opportunity for new governments, citizens, and the international community.
- **The potential advantages from donor coordination and harmonization in terms of pooling arrangements in FCAS are similar to those in non-FCAS** [76]. These include allowing operations on a larger scale, lowering transaction costs, improving dialogue with the government, and greater capacity development in general, including for service delivery.

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Similarly, coordinated revenues can improve both the predictability and stability of fund flow to frontline health services.

- **Even when there are challenges in the implementation of pooled funding arrangements in FCAS there can be considerable value from an institution-building perspective.** An independent evaluation of the Multi Donor Trust Fund in South Sudan, into which the government contributed significant financial resources, found that the greatest positive impact was in terms of institution and capacity building through the development of legislation and other systems for implementation, rather than health related outputs and outcomes [77]. Challenges tend to include high administrative costs, slow disbursement, poor results, which in turn can lead to external funding reverting to parallel channels [76]. Trade-offs exist on a number of issues, including delivering services rapidly and working through government systems to build capacity; low tolerance of fiduciary risk versus capacity development; and external funders focusing on their own visibility at the expense of enhancing government ownership, alignment, and use of country systems [76]. Pooling external funds from different humanitarian agencies for specific purposes, such as centralized procurement of the supplies, starts to reduce fragmentation and increase the harmonization and alignment of supply chain management systems.
- **Efforts to increase domestic funding through contributory-based systems are unlikely to be beneficial and may prove problematic in the longer-term.**

Contributory-based schemes, whether compulsory or voluntary, profit or non-profit, have limited impact on revenues in countries where most employment is informal i.e. non-salaried, and run the risk of increasing fragmentation and increasing inequalities by establishing separate more generous schemes for higher-income individuals [78, 79]. However, while a new funding source does not require a new purchasing agency to be established, it may be politically difficult to introduce such an institution without a new earmarked funding source. In such cases, a dedicated revenue stream (whether from traditional contributory mechanisms, a new earmarked tax, or external funds) may be needed as part of a reform to build purchasing capacity within any newly formed institution e.g. a health insurance fund, or within the MoH, can be particularly valuable for the longer-term development of the health system.

- **Supporting domestic PFM systems and processes represents a core investment which strengthens health system functioning as contributes to future resilience.** While channelling external funds through national systems often comes with higher fiduciary risk than directly through projects or NGOs, these risks can be managed. Strengthening national capacity for procurement, accounting and auditing, reporting and programme implementation is part of the solution but requires time, and may not be the priority during settings of extreme fragility or deficits in government capacity [80]. However, once risks are considered manageable, efforts should be made to support national systems; CBPHFs and MDTFs should progressively align with

national priorities and seek to consolidate smaller projects into scalable national programmes.

- **When refugees need more expensive health services, these should ideally be covered through existing pooling arrangements, as in Iran.** UNHCR promotes the use of health insurance for refugees, and wherever possible existing national schemes, although recognizes that this is often only possible for those resident in the medium to long term [52]. More broadly, UNHCR advocates for refugees to access PHC and emergency services in the same way as nationals, which may include services free at the point of service.

5.2. PURCHASING HEALTH SERVICES POLICY IN FCAS: POLICY CONSIDERATIONS

- **Financing common goods for health⁹ such as disease surveillance, information systems, enforcement of health protection laws and regulations, and planning and management of national strategies for health security, is a priority in all settings, but particularly in FCAS given the increased health risks.** Common goods for health are largely population-based functions that require collective financing. These goods have a

large impact on human life and, due to their inherent market failure, necessitate public financing. As governments in FCAS settings are often unable or unwilling to finance these goods, external funding from humanitarian and development sources can be critical.

- **While a guiding principle of health financing policy is to move away from input-based line item provider payment, in FCAS ensuring basic inputs are in place is greater priority than introducing complex payment systems.** Line-item budgets are useful when purchaser and provider management capacity is low, in particular for financial management and monitoring [82]. In 2017 eight out of ten countries at the bottom of the Corruption Perception Index [83] were also considered fragile [21]; in this context ensuring that public funds are spent for authorized purposes and ensuring the timely disbursement of salaries and key operating expenditures, is the highest priority.
- **In some settings, however, relatively simple output-based payment mechanisms can play a role as part of strategies to reduce out-of-pocket payments and promote access for the poor, while building the foundation for more strategic purchasing.** Cambodia presents an informative case of purchasing reform, in which Health Equity Funds (HEFs) reimburse providers for foregone user fees, removing a significant financial barrier to access for vulnerable households. Initiated by NGOs and supported by development partners in the early 2000s, HEFs have been scaled up nationwide with the government taking over their administration under

9 Traditionally, many of these common goods for health (e.g. surveillance, regulations, subsidies to address large market failures) have been referred to as essential public health functions. However, as described in the paragraph above, these are not always the same and common goods for health have several distinct criteria. For more detailed discussion of the topic see: 81. Smith, P.C., A. Yazbeck, and A. Soucat, *When markets fail: the case for common goods* Health Systems & Reform, forthcoming.

the Payment Certification Agency. The Government now accounts for more than half of the funding required for the HEFs. In terms of strategic directions, the GoC's National Social Protection Policy Framework 2016–2025 (dated August 2016) proposes the establishment of a single payer for all the various schemes, including the Health Equity Funds [84].

- **Pay-for-performance (P4P) can be important in getting resources to front-line providers but has been difficult and costly to implement in FCAS [85, 86] and therefore, should be carefully considered.** It is advisable to review the current approaches to its implementation in low- and middle-income countries, including FCAS, and consider how these can be adjusted to each context, weighting carefully risks and implementation costs, including verification approaches [85, 87]. Moreover, existing evidence demonstrates that P4P works best when it is part of a blended payment system with a base payment (e.g. salaries, fee-for-service, capitation) still playing the main role [88, 89].
- **Pay-for-performance (P4P) initiatives need to coordinate with the broader health financing system and used to focusing multiple funding streams around a common set of priority services.** P4P schemes are often implemented by agencies which operate independently in delineated geographic areas [85]. Bertone et al. 2018 found such schemes being implemented in 23 countries defined as FCAS, largely driven by external organizations. In a few countries, P4P provided a mechanism to streamline donor assistance around a package of priority health services [85, 90].
- **Where new initiatives such as P4P can only be implemented in more stable and secure parts of a country, it important that as soon as fragile settings stabilize, these mechanisms are also extended to these areas, to improve coherence across the health system.** There also needs to be flexibility to shift back to simpler mostly input-based financing if the situation deteriorates. A concerted effort is needed to prevent divergence in health system development which may be perpetuated in the longer-term and embed inequalities for example in terms of the distribution of health staff, and service quality.
- **Where possible, separate purchasing arrangements should not be established for each source of funds, which is a risk when the number of external grants increases significantly.** Examples of purchasers include Health Equity Funds, RBF Units, Programme Management Units (PMUs), health insurance agencies and humanitarian NGOs, all of which purchase health services on behalf of the population using prepaid resources, whether external or domestic. Where separate funding, in particular from humanitarian and development sources, inevitably leads to separate purchasing arrangements, harmonizing underlying policies within and between is critical both for short-term coordination, and for the development of a coherent approach to purchasing in the longer term. Examples include using common or coordinated pay or incentive scales for health workers, and a common or coordinated approach to both tariffs and payment methods for providers, such as harmonized reimbursement for referral and admission costs.

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- **While limiting the number of INGOs supporting a specific geographical area can help to reduce fragmented approaches in purchasing, it is important that all areas follow a coordinated approach** and advance towards further harmonization of purchasing in the humanitarian response between partners supporting service delivery. This would create similar increase in efficiency and effectiveness as seen through contracting with development pooled funding
- **It is important that short-term solutions do not generate longer-term problems, for example by establishing parallel systems with no vision of how these will eventually transition into domestically owned and managed systems.** Challenges remain, however, particularly in relation to the retention of highly qualified staff as they transition to civil servant status [91]. In Afghanistan, an alternative approach was used in the years following conflict, in which a Grant and Contracts Management Unit (GCMU) was established within the MoPH. This unit pooled external funds and followed the financial management rules of the funding agencies. In 2009, the GCMU was restructured into the Health Economics and Financing Directorate (HEFD) of the MoPH with a broader scope of work, and the objective to strengthen the capacity of the MoPH [92].
- **Contracting NGOs to deliver health services using pooled funding, for example during the transition from humanitarian relief to the early-recovery phase, can help to build domestic capacity for purchasing.** In South Sudan, external funds were pooled and used to support PHC in ten states, with one NGO designated as the lead in each county [93]. In Liberia, the Health Sector Pool Fund (HSPF) supported the extension of the Basic Package of Health Services (BPHS) to most public health facilities by 2010, together with a facility accreditation process. The HSPF also helped to build domestic ownership and facilitated coordination between government, local NGOs, and international NGOs by enabling the Ministry of Health and Social Welfare to develop service contracts [94]. Service access was extended as a result, although remained limited for those living in rural areas [95].
- **Experience with the contracting-out of services delivery indicates that quality can be considerably improved within a short period of time [96-98].** The extent to which this approach promotes the longer-term development of the health system depends on the details of implementation. Where possible, government should be actively engaged in the management of NGOs, who are often only accountable to the external agencies funding and contracting them; this approach helps to strengthen government authority and capacity rather than undermine it. Where government's authority is contested and there is an issue of legitimacy, contracting-out or direct provision may be the only feasible option. However, measures should be put in place for transition to government-managed arrangements in the future, as was the case in Cambodia.

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5.3. BENEFITS AND ENTITLEMENT POLICY IN FCAS: POLICY CONSIDERATIONS

- When implemented effectively, explicit statements of a population's entitlements can help to focus resources on priority interventions, address geographical inequities, and improve alignment across purchasers and providers [11, 99]. Basic or essential packages of health services have been introduced in many post-conflict settings such as Afghanistan, Liberia, South Sudan, Somalia, the DRC, and Cambodia, although they often remain aspirational and unrealistic [50]. Other advantages can include a rapid increase in service coverage and a standardization of services, facilities, staffing, drugs and equipment [96, 100, 101].
- Standard benefit packages such as DCP3 can be a useful starting point in FCAS although, as noted above, these need to be adapted to each setting. The Disease Control Priorities (DCP3) programme has proposed both a highest-priority package (HPP) and a larger Essential UHC Package [102], which have been used as the basis for adaptation at the regional and country level, including in FCAS [103], both across and within countries, and recognizing the history of a health system in terms of service delivery design, policies, capacities etc. Evidence indicates that even the HPP is not always realistic in FCAS settings and requires further prioritization.
- It is important to differentiate between benefit decisions as the basis for organizing service provision, which

need to be detailed, from benefit entitlement decisions as the basis for communication to the population which should not be overly detailed. While the principle of common benefit entitlements across the population is important from the perspective of UHC, in practice it is important to adapt services and delivery platforms to the diverse and dynamic contexts often found within a country. Examples included the network approach to adapted referral pathways in north-west Syria, and the clustering of districts for referral in Yemen.

- Coordinating benefit entitlements as far as possible, across FCAS and non-FCAS settings within a country, and progressively moving towards common entitlements and effective coverage for the entire population, is central to UHC. While it is unrealistic to deliver a set of common benefit entitlements nationally when certain geographical areas are fragile or in conflict, it is important to progressively reach out to populations living in insecure and hard to reach areas as soon as feasible.
- Maintaining core processes for benefit design in FCAS to the extent possible is important, including data, dialogue, and political decision [104]. In FCAS, obtaining the necessary data may be more difficult, and similarly dialogue with stakeholders, and political decisions by government. Nevertheless, maintaining these criteria and processes to the extent possible, even when external funding and actors play an increased role, is important given they constitute the fabric of institutions central to the longer-term development of the health system.

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- **Core messages on benefit design with respect to ensuring clarity and transparency regarding entitlements are equally important in FCAS, where health needs tend to increase.** While being explicit about benefit entitlements and related conditions of access is central to ensuring transparency, this should not be confused with being detailed; defining a long list of service entitlements, particularly at the PHC level, can create greater uncertainty for the population, as well as for providers. Making all services available at a PHC facility free at the point of services is an example of an explicit, transparent entitlement, without being overly-detailed.
- **Services for refugees should ideally be managed through existing national schemes, rather than through parallel systems.** Increasingly, UNHCR advises the use of national service delivery channels rather than establishing parallel services for refugees [52]. From a health system perspective, and considering the issues raised by the humanitarian development nexus, incorporating refugees within national health care systems is, wherever possible likely to be more efficient and sustainable. As mentioned earlier, in Uganda refugees were allowed to develop settlements in rural areas and had access to clinics which also served the local populations, an approach which worked well over time [105].
- **While the use of existing public services by refugees is ideal, in some cases this will strain already over-stretched health services unless action is taken to strengthen capacity.** The poorest communities in northern Lebanon have received many of the most

vulnerable Syrian refugees, negatively affecting access to basic services for the host population [46]. UNHCR and other humanitarian agencies can play a key role in improving health services not only for refugees but also for vulnerable host communities. UNHCR has adopted a public health approach which prioritizes affordable and accessible basic PHC and emergency care, over costlier and complex treatments and hospital care, with the aim of ensuring coverage for the greatest number of refugees in Lebanon [106]. The approach to strengthening prevention and primary care services with strict referral systems has the potential to catalyse broader health system reforms.

5.4. CASH AND VOUCHER ASSISTANCE: POLICY CONSIDERATIONS

- **SDG indicator 3.8.2 measures financial protection which in turn requires reducing reliance on out-of-pocket payments;** this principle is particularly pertinent in FCAS settings where population vulnerability tends to increase and household ability to pay reduces. In humanitarian and complex emergencies, there is an agreed interagency policy to suspend user fees for essential health care services [65]. A number of studies in FCAS settings highlight the potential of population-based exemptions and negative effects of user fees in FCAS [107, 108].
- **In settings where out-of-pocket payments persist or re-emerge, CVA can be used to reduce financial barriers to accessing services while mitigation**

measures are put in place through improved revenue raising, pooling and purchasing as described above [56]. These can also be used to offset other costs, such as transportation, or opportunity cost of time, and can empower the service users. Existing research from FCAS and non-FCAS shows the general effectiveness of these interventions in improving service utilization.

- **Vouchers can improve service utilization for target populations and services in certain FCAS settings.** A number of studies demonstrate the effectiveness of vouchers in stimulating service use [57, 109], particularly among women and children [59]. There is evidence that competitive vouchers schemes can drive up the quality and efficiency of service delivery by both public and private providers and contribute to equity, as in the case of Nicaragua [110]. In addition, monitoring contracts with providers requires greater information reporting, strengthening the health information system in the process; they may also help to strengthen systems for financial management and quality management but can be expensive and time-consuming to establish [56]. This approach has been successfully used in acute emergencies in Syria and Yemen.
- **Conditional cash transfers in development contexts can significantly stimulate demand and increase use of preventive services but need to be better understood in humanitarian contexts** [111-113]. Conditional cash transfers are typically a component of social support programmes, which make regular cash payments to poor households conditional on the use of certain health services

and school attendance. Introducing conditionalities requires new systems to monitor compliance, which has financial and administrative costs. In some cases, negative side effects have been identified, such as the unfair penalization of families who cannot comply with the conditions for reasons beyond their control.

- **While research shows that multipurpose cash transfers (MPCTs) can improve access to commodities [114], non-health sector products (e.g. food) with health benefits, increase choice for beneficiaries, enhance dignity, and have a beneficial effect on local economic activity, there are concerns that over-reliance on this instrument will divert resources from other actions needed to improve access to health services.** Most studies of cash-based approaches focus on non-health benefits, such as food security; a recent review concludes that in terms of transaction costs, cash transfers can be an efficient way of providing humanitarian assistance. Unconditional, unrestricted 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 [115]. A variety of card-based systems and mobile transfers can also reduce costs and be implemented rapidly. However, in relation to health care, unconditional, unrestricted cash transfers may not work as well as they do for food, in particular for high cost care [56]; the unpredictable nature of need for such care means that cash should be considered as a supplement to, and not a substitute for, pooled funding arrangements.

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- Where the value of MPCTs includes costs related to accessing health services, they should be seen as complementary assistance to supply-side efforts to improve health services, ensuring consistency with current agreements to provide essential health services free at the point of access [65]. However, in practice even essential

services are often not free at the point of service, with households often reporting using MPCTs to pay for health services; further evidence is required to understand exactly what people spend MPCTs on in FCAS, but ideally these are only to be used to cover indirect costs such as transport, and services not considered to be essential.

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ANNEX 1: INSTITUTIONAL CLASSIFICATIONS OF FRAGILITY

Since 2000 there has been a growing attention in the literature and beyond on fragility, both in terms of fragile states, but also fragile settings within states, with a wide variety of interpretations of the concept by academics and international agencies. A summary of the main categorizations of fragility are presented below, with further details available in the literature review:

- 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 settings, from Afghanistan and Eritrea to DRC, Cote d’Ivoire, Kosovo and Myanmar; several countries with from subnational 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 United Kingdom Aid Strategy (2015) provides a list of 54 fragile states, distinguishing between “high fragility” e.g. Afghanistan, Eritrea, and Democratic People’s Republic of Korea, “moderate fragility” e.g. 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 conceptualized around the concept of 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/donor-info/g3_contributions/en/
- The G7+ has embarked on its 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. There are currently 20 countries:

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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.

COMMON CONCEPTS UNDERPINNING LITERATURE ON FRAGILITY

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, 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). McLoughlin (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).

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 organizations. 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. While 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.

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ANNEX 2: THE DYNAMIC NATURE OF FRAGILITY

While states of fragility are **dynamic** 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.).

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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".

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REFERENCES

1. *Transcending humanitarian-development divides: Changing People's Lives: From Delivering Aid to Ending Need. Commitment to Action.*, in *World Humanitarian Summit 2016, Agenda for Humanity*: Istanbul, Turkey.
2. OECD, *States of Fragility 2018*. 2018.
3. Martineau, T., et al., *Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states*. *BMJ Global Health*, 2017. **2**(2): p. e000327.
4. WHO Regional Office for the Eastern Mediterranean. *WHO Health Emergencies – Countries in Crisis*. 2019 [cited 2018; Available from: <http://www.emro.who.int/eha/countries-in-crisis/index.html>].
5. WHO Regional Office for Africa. *Weekly bulletins on outbreaks and other emergencies*. 2019 [cited 2019 20 February 2019]; Available from: <https://www.afro.who.int/health-topics/disease-outbreaks/outbreaks-and-other-emergencies-updates>.
6. UNHCR. *Coordination in Complex Emergencies*. 2001 [cited 2019 30 April 2019]; Available from: <https://www.unhcr.org/partners/partners/3ba88e7c6/coordination-complex-emergencies.html>.
7. World Health Organization, *The world health report 2000. Health systems: improving performance*. 2000, World Health Organization: Geneva.
8. World Health Organization, *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action 2007*: Geneva.
9. Kutzin, J., *A descriptive framework for country-level analysis of health care financing arrangements*. *Health Policy*, 2001. **56**(3): p. 171-204.
10. World Health Organization and The World Bank, *Tracking universal health coverage: 2017 global monitoring report*. 2017 Geneva.
11. Kutzin, J., et al., *Developing a national health financing strategy: a reference guide*, in *Health financing guidance*. 2017: Geneva.
12. World Health Organization, *Health Financing Progress Matrix: real-time assessment of country health financing policy in support of UHC*, in *Health financing guidance*. forthcoming: Geneva, Switzerland.

FINAL DRAFT

13. Witter, S., *Health financing in fragile and post-conflict states: What do we know and what are the gaps?* Social Science & Medicine, 2012. **75**(12): p. 2370-2377.
14. Call, C.T., *Beyond the 'failed state': Toward conceptual alternatives.* European Journal of International Relations, 2010. **17**(2): p. 303-326.
15. Inter-Agency Standing Committee, *Towards a typology of response scenarios in protracted settings.* Unpublished.
16. Spiegel, P.B., et al., *Health-care needs of people affected by conflict: future trends and changing frameworks.* The Lancet, 2010. **375**(9711): p. 341-345.
17. Witter, S., et al., *Background note on health financing in fragile and conflict-affected settings, in Health financing working paper.* forthcoming: Geneva, Switzerland.
18. Ljubic, B., B. Hrabac, and Z. Rebac, *Reform of health insurance in the Federation of Bosnia and Herzegovina.* Croat Med J, 1999. **40**(2): p. 160-5.
19. Abu-Zaineh, M., et al., *Measuring and decomposing socioeconomic inequality in health care delivery: A microsimulation approach with application to the Palestinian conflict-affected fragile setting.* Soc Sci Med, 2011. **72**(2): p. 133-41.
20. Laokri, S., R. Soelaeman, and D.R. Hotchkiss. *Assessing out-of-pocket expenditures for primary health care: how responsive is the Democratic Republic of Congo health system to providing financial risk protection?* BMC Health Serv Res, 2018. **18**(1): p. 451.
21. The World Bank. *Harmonized List of Fragile Situations FY10 – FY13.* 2019 [cited 2019 16 January 2019]; Available from: <http://pubdocs.worldbank.org/en/963681410886171483/FY10toFY13Harmonized-list-Fragile-Situations.pdf>.
22. Abramowitz, S., *Humanitarian morals and money: health sector financing and the prelude to the Liberian Ebola epidemic* Critical African Studies, 2016. **8**(3): p. 319-334.
23. Kieny, M.-P., et al., *Health-system resilience: reflections on the Ebola crisis in western Africa.* Bulletin of the World Health Organization, 2014. **92**(12): p. 850-850.
24. Newbrander, W., R. Waldman, and M. Shepherd-Banigan, *Rebuilding and strengthening health systems and providing basic health services in fragile states.* Disasters, 2011. **35**(4): p. 639-60.
25. IMF, *Building Fiscal Capacity in Fragile States.* 2017, International Monetary Fund.

FINAL DRAFT

26. Mòdol, X. *Health Financing Systems Challenges in the Context of Acute and Chronic Conflicts in EMR. Presentation.* in *Health Financing under Acute and Chronic Emergencies in the Context of the Eastern Mediterranean Region*. 2018. Cairo, Egypt: WHO Regional Office for the Eastern Mediterranean.
27. Weiss Fagen, P. and M.N. Bump, *Remittances in Conflict and Crises: How Remittances Sustain Livelihoods in War, Crises and Transitions to Peace*, in *The Security-Development Nexus Program Policy Paper*. 2006.
28. Hill, P.S., et al., *The “empty void” is a crowded space: health service provision at the margins of fragile and conflict affected states*. *Confl Health*, 2014. **8**: p. 20.
29. Lipcan, A., R. Zaman, and G. Maschaupt, *Assessing the costs of private health care in Somalia*. 2018.
30. De Vries, A.K. and N.S. Klazinga, *Mental health reform in post-conflict areas: a policy analysis based on experiences in Bosnia Herzegovina and Kosovo*. *Eur J Public Health*, 2006. **16**(3): p. 247-52.
31. United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Common Humanitarian Fund in Afghanistan: Annual Report 2017*, in *CBPF Annual Reports*. 2018.
32. The Afghanistan Reconstruction Trust Fund. *Better Health Outcomes for Women, Children, and the Poor*. 2019 [cited 2019 15 April 2019]; Available from: <http://www.artf.af/results/artf-at-work/better-health-outcomes-for-women-children-and-the-poor>.
33. Barr, A., et al., *Health sector fragmentation: three examples from Sierra Leone*. *Globalization and health*, 2019. **15**(1): p. 8-8.
34. Pavignani, E., et al., *Making sense of apparent chaos: health-care provision in six country case studies*. *International Review of the Red Cross*, 2013. **95**(889): p. 41-60.
35. Cometto, G., G. Fritsche, and E. Sondorp, *Health sector recovery in early post-conflict environments: experience from southern Sudan*. *Disasters*, 2010. **34**(4): p. 885-909.
36. Bernardi, M., T. Hart, and G. Rabinowitz, *EU State Building Contracts: early lessons from the EU's new budget support instrument for fragile states*. 2015: London.
37. World Bank, *Conflict, Security, and Development*, in *World Development Report 2011* 2011: Washington, DC.
38. United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Country-Based Pooled Funds and the Grand Bargain*. 2017.

FINAL DRAFT

39. Stasse, S., et al., *Improving financial access to health care in the Kisantu district in the Democratic Republic of Congo: acting upon complexity*. Global health action, 2015. **8**: p. 25480-25480.
40. Barroy, H., et al., *Investing in Universal Health Coverage: Opportunities and Challenges for the Democratic Republic of Congo*, in *Public Expenditure Review*. 2014, World Bank: Washington, DC.
41. United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Operational Handbook for Country-based Pooled Funds* (Version 1.2). 2017.
42. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). *Central Emergency Response Fund: Guidance and Templates*. 2019 [cited 2019 14 March 2019]; Available from: <https://cerf.un.org/partner-resources/guidance-and-templates>.
43. Kalambay Ntembwa, H. and W. Van Lerberghe, *Democratic Republic of the Congo: Improving aid coordination in the health sector, in Improving health system efficiency*. 2015: Geneva, Switzerland.
44. Bertone, M.P., et al., *Performance-based financing in three humanitarian settings: principles and pragmatism*. Conflict and Health, 2018. **12**(1): p. 28.
45. Blanchet, K., F.M. Fouad, and T. Pherali, *Syrian refugees in Lebanon: the search for universal health coverage*. Conflict and Health, 2016. **10**(1): p. 12.
46. Johns Hopkins University Bloomberg School of Public Health, et al., *Syrian Refugee and Affected Host Population Health Access Survey in Lebanon*. 2015: Geneva, Switzerland.
47. Bertone, M.P. and S. Witter, *An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone*. Social Science & Medicine, 2015. **141**: p. 56-63.
48. The Sphere movement, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*. 2018, Geneva, Switzerland: The Sphere movement.
49. Inter-Agency Working Group on Reproductive Health in Crises. *The Minimum Initial Service Package (MISP) for reproductive health (RH)*. 2019 [cited 2019 30 April 2019]; Available from: <http://iawg.net/areas-of-focus/misp/>.
50. Modol, X. and S. Colombo, *The essential package of health services in humanitarian crises: a review*. 2017: Geneva, Switzerland.
51. Mathew, J. and O. Abiodun, *The Essential Package of Health Services and Health Benefit Plans in Democratic Republic of the Congo*, in Brief. 2017: Washington, DC.

FINAL DRAFT

52. UNHCR, *A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR*. 2012: Geneva, Switzerland.
53. Alfred, C., *Rethinking How Refugees Get Medical Care*. Q&A with Paul Spiegel, in *Refugees Deeply*. 2016, NewsDeeply.
54. Medecins Sans Frontieres, *Taxing the ill: how user fees are blocking universal health coverage*. 2017.
55. Medecins Sans Frontieres, *Between Rhetoric and Reality: The Ongoing Struggle to Access Health care in Afghanistan*. 2014.
56. World Health Organization and Global Health Cluster Cash Task Team, *Working paper for considering cash transfer programming for health in humanitarian contexts*. 2018: Geneva, Switzerland.
57. Boddam-Whetham, L., et al., *Vouchers in Fragile States: Reducing Barriers to Long-Acting Reversible Contraception in Yemen and Pakistan*. *Glob Health Sci Pract*, 2016. **4 Suppl 2**: p. S94-s108.
58. Grainger, C.G., et al., *Providing safe motherhood services to underserved and neglected populations in Yemen: the case for vouchers*. *Journal of International Humanitarian Action*, 2017. **2**(1): p. 6.
59. Balan, M. *Reproductive health vouchers: improving women's access to emergency obstetric care in the violence affected areas in Syria*. Presentation.. in *Fifteenth Annual Meeting of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises*. 2015. Dead Sea Region, Jordan Inter-Agency Working Group (IAWG) on Reproductive Health in Crises.
60. Lin, A. and A.S. Salehi, *Stimulating demand: effects of a conditional cash transfer programme on increasing maternal and child health-service utilization in Afghanistan, a quasi-experimental study*. *The Lancet*, 2013. **381**: p. S84.
61. Witvorapong, N. and A.I. Foshanji, *The impact of a conditional cash transfer program on the utilization of non-targeted services: Evidence from Afghanistan*. *Soc Sci Med*, 2016. **152**: p. 87-95.
62. The Cash Learning Partnership (CaLP), *Glossary of Terminology for Cash and Voucher Assistance*. 2018: Oxford, United Kingdom.
63. World Bank, *Cash Transfers in Humanitarian Contexts. Final draft prepared for the Principals of the Inter-Agency Standing Committee*. 2016: Washington, DC.

FINAL DRAFT

64. The Agenda for Humanity, *The Grand Bargain – A Shared Commitment to Better Serve People in Need*. 2016: Istanbul, Turkey.
65. Global Health Cluster and Inter-Agency Standing Committee, *Global Health Cluster Position Paper: Removing User Fees for Primary Health care Services during Humanitarian Crises*. Prehospital and Disaster Medicine, 2017. **25**(4): p. 374-376.
66. Cashin, C., et al., *Aligning Public Financial Management and Health Financing: Sustaining Progress Toward Universal Health Coverage*, in *Health Financing Working Paper*. 2017, World Health Organization: Geneva.
67. World Health Organization, *Public financing for health in Africa: from Abuja to the SDGs*. 2016, World Health Organization: Geneva.
68. Le Gargasson, J.B., et al., *Budget process bottlenecks for immunization financing in the Democratic Republic of the Congo (DRC)*. Vaccine, 2014. **32**(9): p. 1036-42.
69. Sparkes, S., A. Duran, and J. Kutzin, *A System-Wide Approach to Analysing Efficiency across Health Programs*, in *Health Financing Working Paper*. 2017, World Health Organization: Geneva.
70. Porter, D., et al., *Managing Public Finance and Procurement in Fragile and Conflicted Settings*, in *World Development Report 2011 Background Paper*. 2010: Washington, DC.
71. World Bank, *Public Financial Management Reforms in Post-Conflict Countries: Synthesis Report*, in *Working Paper*. 2012: Washington, DC.
72. OECD, *Domestic Revenue Mobilization in Fragile States*. 2014, OECD: Paris.
73. Salama, P., et al., *Post-crisis Zimbabwe's innovative financing mechanisms in the social sectors: a practical approach to implementing the new deal for engagement in fragile states*. BMC International Health and Human Rights, 2014. **14**(1): p. 35.
74. Hughes, J., A. Glassman, and W. Gwenigale, *Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund in Working Paper* 2012: Washington, DC
75. ODI, *EU State Building Contracts: early lessons from the EU's new budget support instrument for fragile states*. February 2015, Overseas Development Institute: London, United Kingdom.
76. Commins, S., et al., *Pooled funding to support service delivery: Lessons of experience from fragile and conflict-affected states*, in *Briefing*. 2013: London.
77. FIAIS, *Independent Evaluation of the Multi Donor Trust Fund- South Sudan*. 2013, Fafo Institute for Applied International Studies.

FINAL DRAFT

78. Jowett, M. and J. Kutzin, *Raising revenues for health in support of UHC: strategic issues for policy-makers*, in *Health financing policy brief*. 2015: Geneva.
79. Kutzin, J., W. Yip, and C. Cashin, *Alternative Financing Strategies for Universal Health Coverage*, in *World Scientific Handbook of Global Health Economics and Public Policy*, R.M. Scheffler, Editor. 2016, World Scientific Publishing Co Pte Ltd. p. 267-309
80. Manuel, M., et al., *Innovative aid instruments and flexible financing: providing better support to fragile states*, in *Briefing papers*. 2012: London.
81. Smith, P.C., A. Yazbeck, and A. Soucat, *When markets fail: the case for common goods* Health Systems & Reform, forthcoming.
82. Cashin, C., et al., *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage*. 2015, Joint Learning Network for Universal Health Coverage.
83. Transparency International. *Corruption Perception Index 2017*. 2018 [cited 2019 16 January 2019]; Available from: https://www.transparency.org/news/feature/corruption_perceptions_index_2017.
84. Khim, K., P. Ir, and P.L. Annear, *Factors Driving Changes in the Design, Implementation, and Scaling-Up of the Contracting of Health Services in Rural Cambodia, 1997–2015*. Health Systems & Reform, 2017. 3(2): p. 105-116.
85. Soucat, A., et al., *Pay-for-Performance Debate: Not Seeing the Forest for the Trees*. Health Systems & Reform, 2017. 3(2): p. 74-79.
86. Cashin, C., L. Fleisher, and T. Hashemi, *Verification of performance in results-based financing (RBF): the case of Afghanistan*, in *Health, Nutrition and Population (HNP) Discussion Paper*. 2015: Washington, DC.
87. Josephson, E., et al., *Verification in PBF – the way forward for low- and lower-middle income countries*, in *Financing Health in Africa – Le blog*. 2018, Financing Health in Africa
88. OECD, *Better Ways to Pay for Health Care*. 2016, Paris: OECD Publishing.
89. Mathauer, I., et al., *Purchasing health services for universal health coverage: how to make it more strategic?*, in *Health financing policy brief*. 2019: Geneva.
90. Rusa, L., et al., *Rwanda: Performance-Based Financing in the Public Sector*, in *Performance Incentives for Global Health: Potential and Pitfalls*, R. Eichler, R. Levine, and Performance-Based Incentives Working Group, Editors. 2009, Center for Global Development: Washington, DC. p. 189 – 214.

FINAL DRAFT

91. Bizhan, N., *Building legitimacy and state capacity in protracted fragility: The case of Afghanistan*. 2017: London, United Kingdom.
92. Beaston-Blaakman, A., et al., *Public Administration Reform in a Challenging Environment: A Review of the Establishment of the Health Economics and Financing Directorate (HEFD) within the Afghanistan Ministry of Public Health* International Journal of Public Administration, 2011. **34**(6): p. 359-365.
93. Jones, A., N. Howard, and H. Legido-Quigley, *Feasibility of health systems strengthening in South Sudan: a qualitative study of international practitioner perspectives*. BMJ Open, 2015. **5**(12): p. e009296.
94. Lee, P.T., et al., *An analysis of Liberia's 2007 national health policy: lessons for health systems strengthening and chronic disease care in poor, post-conflict countries*. Globalization and Health, 2011. **7**(1): p. 37.
95. Kruk, M.E., et al., *Availability of essential health services in post-conflict Liberia*. Bull World Health Organ, 2010. **88**(7): p. 527-34.
96. Loevinsohn, B. and G.D. Sayed, *Lessons from the health sector in Afghanistan: how progress can be made in challenging circumstances*. Jama, 2008. **300**(6): p. 724-6.
97. Soeters, R. and F. Griffiths, *Improving government health services through contract management: a case from Cambodia*. Health Policy Plan, 2003. **18**(1): p. 74-83.
98. Blaakman, A. and A. Lwin, *Afghanistan Basic Package of Health Services (BPHS) Study: Cost-Efficiency, Quality, Equity and Stakeholder Insights into Contracting Modalities*. 2013: Washington, DC.
99. Eldon, J., C. Waddington, and Y. Hadi, *Health System Reconstruction: Can It Contribute to State-building?* 2008: London.
100. Petit, D., et al., *Implementing a Basic Package of Health Services in post-conflict Liberia: perceptions of key stakeholders*. Soc Sci Med, 2013. **78**: p. 42-9.
101. World Health Organization, *Essential Health Packages: What are they for? What do they change?*, in *WHO Service Delivery Seminar Series Technical Brief*. 2008: Geneva, Switzerland.
102. Watkins, D., et al., *Universal Health Coverage and Essential Packages of Care*, in *Disease Control Priorities (third edition)*, D. Jamison, et al., Editors. 2017, World Bank.: Washington, DC.
103. Mirza, Z., et al., *'Health Benefits Package': a centerpiece of Universal Health Coverage*. East Mediterr Health J, 2018. **24**(4): p. 405-406.

FINAL DRAFT

104. Terwindt, F., D. Rajan, and A. Soucat, *Priority-setting for national health policies, strategies and plans*, in *Strategizing national health in the 21st century: a handbook*, G. Schmets, D. Rajan, and S. Kadandale, Editors. 2016, World Health Organization: Geneva. p. 159-231.
105. WHO Regional Office for Africa, *Health of refugees and migrants. Practices in addressing the health needs of refugees and migrants*. 2018.
106. UNHCR. 2015. *Syria Regional Refugee Response – Inter-agency Information Sharing Portal* [Online]. Geneva: UNHCR. Available: <http://data.unhcr.org/syrianrefugees/regional.php> [Accessed August 20th 2015 2015].
107. Witter, S., et al., *The free health care initiative in Sierra Leone: Evaluating a health system reform*, 2010-2015. *Int J Health Plann Mgmt*, 2016. **33**: p. 434-448.
108. Steinhardt, L.C., et al., *The effects of user fees on quality and utilization of primary health-care services in Afghanistan: a quasi-experimental health financing pilot study in a post-conflict setting*. *Int J Health Plann Manage*, 2013. **28**(4): p. e280-97.
109. Hunter, B.M., et al., *The effects of cash transfers and vouchers on the use and quality of maternity care services: A systematic review*. *PLOS ONE*, 2017. **12**(3): p. e0173068.
110. Borghi, J., et al., *The cost-effectiveness of a competitive voucher scheme to reduce sexually transmitted infections in high-risk groups in Nicaragua*. *Health Policy Plan*, 2005. **20**(4): p. 222-31.
111. Bastagli, F., et al., *Cash transfers: what does the evidence say? A rigorous review of impacts and the role of design and implementation features*. 2016: London, United Kingdom.
112. Lagarde, M., A. Haines, and N. Palmer, *The impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries*. *Cochrane Database Syst Rev*, 2009(4): p. Cd008137.
113. Glassman, A., et al., *Impact of Conditional Cash Transfers on Maternal and Newborn Health*. *Journal of Health, Population, and Nutrition*, 2013. **31**(4 Suppl 2): p. S48-S66.
114. Fabre, C. and R. Aggiss, *Cash-Based Response*, in *The Commitments into Action Series*, N. Gbessa, B. Killen, and R. Scott, Editors. 2017: Paris.
115. Doocy, S. and H. Tappis, *Cash-based approaches in humanitarian emergencies: a systematic review*, in *Campbell systematic reviews*. 2017: Oslo, Norway.

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