Netherlands Platform for
Global Health Policy and
Health Systems Research

Strategy for Dutch engagement in health recovery processes in fragile states

Building on contemporary policies, practice and science

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EXECUTIVE SUMMARY

This document: "Strategy for Dutch engagement in health recovery processes in fragile states" is an advice of the Netherlands Platform for Global Health Policy and Health Systems Research (Platform) to the Dutch Ministry of Foreign Affairs, upon request of the Dutch Ministry of Foreign Affairs. The policy question to the Platform formulated in 2008 was: "Which policy options aimed at supporting health recovery processes in fragile states can be considered by The Netherlands, within the general policy framework formulated for fragile states?".

Hence, the starting point of this document is the new policy framework of the Ministry of Foreign Affairs, as elaborated in the following policy memoranda:

1) "Cabinet Agenda 2015" and Policy Memorandum "A common concern" (2007)
2) Development cooperation 2.0 (2008)
3) "Security and development in fragile states" (2008)
4) "Choices and opportunities", on HIV/AIDS and Sexual and Reproductive Health and Rights in foreign policy (2008)

This document aims to provide strategic and practical advice on how to ensure that health recovery efforts in fragile states have maximum impact on health systems and health status. It has a particular focus on Dutch country programs for Afghanistan, Burundi, DR Congo and Sudan in particular. This document is prepared for the Ministry of Foreign Affairs but it should also interest a wider audience of policy makers, analysts, health and development practitioners and researchers interested in the field. Within the document, strategies for development and synergy are offered for consideration of:

- The Minister for Development Cooperation and relevant policy departments of the Ministry of Foreign Affairs, notably the Department of Health, Gender and Civil Society (DSI), and the Fragile States and Peace building Unit (EFV);
- The embassies in Afghanistan, Burundi, DR Congo and Sudan;
- Dutch NGOs active in health recovery in fragile states;
- Interested researchers and research funding agencies.

As described in section 1 (introduction), the health status of the populations living in fragile states is generally below the targets formulated in the Millennium Development Goals. Health services in conflict and post-conflict settings are largely ineffective, inefficient and inequitable. Research points to the fact that the failure of health systems to deliver and finance essential health services, to attract and maintain an effective workforce, to work with local communities and to reach the poor and vulnerable populations are a major barrier to the achievement of the Millennium Development Goals 4,5 and 6. The effects on women's health and Millennium Development Goal 5 appear to be particularly severe, as is shown by very poor access to reproductive health services and un-proportionally high maternal mortality rates reported under those circumstances. Failing health systems also hamper socio-economic development at large, as there are tangible links between health systems, equity and wealth as noted by the reports of the high-level WHO Commissions on Social Determinants of Health[1], and Macro-Economics and Health[2].

[1] WHO Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* WHO, 2008

[2] WHO Commission on Macro-Economics and Health. *Investing in health for economic development.* WHO, 2001

Unfortunately, health and health systems development are usually only minor items on the agenda of local decision-makers in fragile states and the international diplomatic corps. Security, political processes and human rights issues dominate.

1. Security, human rights and government legitimacy issues also dominate the policy memorandum on "Security and development in fragile states" (hereafter called the 'Fragile States Strategy') and Dutch country assistance programs formulated by the embassies in Afghanistan, Burundi, DR Congo and Sudan (see section 2). Health is not high on the agenda, with some exceptions. However, this does not mean that the Netherlands is not active in the health sector of fragile states. The Netherlands is an important contributor to trust funds and multilateral organizations such as UNFPA and the World Bank. It also supports NGOs active in basic health services and health systems strengthening in a number of fragile states. Having said so, resources spent on health and health systems are relatively small (and often un-earmarked) compared to resources spent on defense efforts, government-building and elections, and (other) human rights issues. Therefore:

The Platform encourages the Ministry of Foreign Affairs and its partners to strengthen the position and visibility of health and health systems on the policy agenda of fragile states and within its own country assistance programs.

2. Now that the policy framework of the Minister is in place, it is time for the Fragile States & Peace building Unit (EFV) and the Division of Health & Aids (DSI/SB) to step-up communication, cooperation and coordination. There are a number of important questions related to priority-setting, resource allocation, implementation partners, and information, research and coordination needs (see section 2.2) requiring study and debate. The Platform offers to support the Ministry of Foreign Affairs in addressing some of these, for example by organizing seminars or expert meetings.

   As announced in a presentation on 2 April 2009 ("Knowledge on the move"), the Minister aims to establish knowledge circles (*'kenniskringen')* covering the 4 strategic priorities indicated in the policy memorandum "Our common concern", among which are Fragile States and Women/Sexual and Reproductive Health and Rights. The Platform encourages the Minister to do so and to include appropriate health and health systems expertise within both of these knowledge circles. In fact, the Platform itself has been functioning as a kind of knowledge circle 'avant la lettre'. An evaluation of its role and performance in policy advice was made by the Platform in March 2009 upon the request of the Division of Health & Aids. The results of this exercise are available to the Minstry of Foreign Affairs. There are important lessons to be drawn about the set-up, functioning and effectiveness.

Implementation requires coordinated efforts of the Ministry of Foreign Affairs policy divisions – notably the Division of Health and AIDS (DSI/SB) and the Fragile States and Peace building Unit (EFV) – and cooperation with other partners engaged in policy, science and (business) practice. Knowledge is an essential ingredient, and the Platform offers to share its experience and to be an active partner in future 'knowledge circles'.

3. Why is there such a shortfall in reaching the health-related Millennium Development Goals in fragile states? Section 3 describes that part of the reason is that, in fragile states, delivery and scaling up of health services is more difficult than other low-income settings. This is due to poorer governance, severe human resource and financial constraints, and extra problems in access to essential services faced by the local population. Resource constraints are further exacerbated both

by a contested policy environment and a reliance on international aid, which results in extreme volatile funding. It also makes harmonization and alignment more challenging to the detriment of aid effectiveness.

However, there is a growing body of evidence world-wide suggesting that progress towards the health-related Millennium Development Goals is needed and possible even in these most difficult and complex situations and countries. Even more so, research indicates that remarkable progress can be made within a rather short time period in post-conflict settings if effective use is made of the existing opportunities. It does require political will and a coordinated policy and implementation response, including funding, of the local authorities and the international community. This response should focus on joint health and health system needs assessment, establishing accessible and equitable basic health services, continuation (at least for some time) of humanitarian aid and implementation of targeted disease-specific programs.

Health recovery in fragile states faces multiple challenges and requires attention to meet the immediate health needs of conflict-affected populations, establish functioning basic health services and rehabilitate adequate health system governance structures. Improvements in health can be made when the opportunities for quick and coordinated scaling-up of essential services are used effectively.

4. The Ministry of Health in Afghanistan, South Sudan, DR Congo and a number of other post-conflict countries (e.g. Liberia and Cambodia) have all adopted the Basic Package of Health Services approach (BPHS) as central strategy to health recovery (see section 3). The Basic Package of Health Services is usually executed by pooling of funds and implementation through a contracting modality to NGOs. To date countries such as Afghanistan are reporting primary healthcare coverage of 83% since the introduction of contracting in 2003. Such strategies include maternal, newborn and reproductive health as well as child health, nutrition and communicable diseases. The Basic Package of Health Services is certainly part of the solution towards increasing coverage of quality healthcare which has potential to improve availability and use of essential maternal and reproductive health services. However, there are also shortcomings to this approach. The main gaps highlighted in a comprehensive review of the Basic Package of Health Services are services addressing maternal health and sexual and gender based violence, despite ample evidence of the high rates of maternal mortality and violence against women during and after conflict as noted in DR Congo and Southern Sudan. Equally mental health services are not included in some countries where the needs are greatest in such post conflict settings.

   With specific focus on safe motherhood and associated reproductive health morbidity, the evidence suggests that progress is made where *strategies have been more comprehensive and multidimensional.* It is evident that strategies which have had most impact have moved beyond medical interventions, while adopting an integrated approach to include girls' education, work on increasing the age of marriage and first pregnancy, family planning and abortion services and efforts to reach out to young people.

Designing and implementing a Basic Package of Health Services, based on adequate health needs assessment is a tested and proved strategy for health recovery in fragile states. The Netherlands could pay special attention to inclusion of comprehensive sexual and reproductive health services within the basic health packages designed in fragile states.

5. While major inequities exist in access to basic health services in fragile states, strategies to address such deficits can only be achieved through a comprehensive package of essential basic services that also addresses the wider determinants of health (education, nutrition, water and sanitation etc.). Health recovery processes should therefore be firmly embedded in multi-sectoral responses to alleviate poverty and underdevelopment.

   Section 4 describes that attention to donor policy and related aid mechanisms is needed to effect implementation of health recovery programs and scale-up of essential services. The complexity of some of the aid mechanisms used and the limitations to available capacity to implement them saw a (potential) disruption to the service delivery in several countries. As an example, Afghanistan (-19%) and Burundi (-86%) witnessed reduction in aid allocations for maternal health in the post-conflict stage despite pledges and needs. In addition to reduction in much needed funding, disbursements are found to be highly volatile, condition-bound and unpredictable which challenges planning and fulfillment of strategic priorities. Therefore, an integrated mix and sequencing of aid modalities is needed in early recovery settings, that is focused on outcomes in the local setting (development effectiveness). The former practice of progressively advancing from aid mechanisms which focus primarily on health service delivery and are state avoiding in nature, to those which are partnering with the state to strengthen the health system, requires rethinking. A paradigm shift is required, which allows for an integrated mix and sequencing of modalities used to balance the multiplicity of objectives (state, non-state, systems building, service delivery, outcomes) in early recovery settings.

   The Netherlands is one of the donor countries that is supporting and experimenting with more flexible funding approaches that focus on needs and outcomes on the continuum of humanitarian and development objectives. This is very positive. As the Netherlands is a significant donor to multi-donor trust funds and international organizations, it is well placed to advocate for donor assistance that concentrates on identifying and supporting short- and medium/long-term recovery objectives in the local setting, with donor agencies coordinating their support at country level, including choice of aid instruments and their complementarity. This should ensure that urgent medical assistance for vulnerable populations is maintained while simultaneously a start can be made with (re-)building the health system.

Multi-sectoral, flexible and needs-based funding approaches are key to prevent for disruption of essential services, including healthcare. The Netherlands should advocate for coordinated donor assistance strategies that acknowledge the continuum of short-term emergency needs AND longer-term system aspects in the local setting as primary development assistance objectives.

6. As described in section 5, Afghanistan, Burundi, DR Congo and Sudan each have a government backed and up-to-date overall strategic framework in place for the health sector, such as a Poverty Reduction Strategy or health sector strategy. In addition, country-level specific HIV/AIDS and/or reproductive health strategies and policies are also in place. Hence, the challenge lies not so much in policy development, but in its funding and implementation.

   As for Dutch assistance to those locally defined health sector strategies, it is first of all important to point out that none of the embassies in Afghanistan, Burundi, DR Congo and Sudan have identified health as a prime assistance sector, hence none are so-called *health partner countries of the Ministry of Foreign Affairs*. All in all, the relatively low priority given to health recovery as opposed to other policy agendas is reflected into limited and/or invisible (earmarked) bi-lateral

resources available for the health sector of Afghanistan, Burundi, DR Congo and Sudan. Despite this, the Netherlands should give some priority to provide financial contributions in support of these local strategies, most notably to funding the Basic Package of Health Services. Alternatively, it may advocate with the multilateral organization it supports or for other donors to take on this responsibility.

The Netherlands could make a difference to analyze needs and gaps in accessibility and coverage of essential health services in those areas that have strategic priority, most notably reproductive health services and mental health. This would help to better targeting country-level health interventions and donor support strategies. The Ministry of Foreign Affairs should continue to take a pro-active role to raise awareness and mobilize other donors through diplomatic and other efforts. Especially now, as there is a window of opportunity opening for renewed discussion on some controversial issues (notably related to sexual health and abortion) due to the change in the USA's leadership. Finally, The Netherlands should continue to support NGOs to fill gaps in service provision and community empowerment strategies.

In Afghanistan, Burundi, DR Congo and Sudan, there are a number of opportunities to address Sexual and Reproductive Health and Rights within the current policy environment formulated at local level, in cooperation with the major donors and international agencies. In all countries, The Netherlands could consider co-funding of the Basic Package of Health Services and targeted interventions to support health (sector) needs assessment and Sexual and Reproductive Health and Rights service delivery.

7. As described in section 6, the transition from relief to development assistance has been highlighted as crucial in most of the embassy plans in Afghanistan, Burundi, DR Congo and Sudan. The embassies can play a contributing role at country level to ensure that the different aid mechanisms and their financial procedures are well-adapted to the specific country context and capacities.
   None of the Dutch embassies in Afghanistan, Burundi, DR Congo and Sudan employ a health sector specialist. The organization and staff deployment at embassy level means that essential diplomatic tasks, such as high-level agreements and advocacy for health system recovery, are in principle covered but that the operational capabilities to play a (pro-) active and significant role in the health arena are limited. However, the embassies sometimes have important roles to play, for example the DR Congo embassy as co-secretariat of the Working Group Sexual Violence, the Afghanistan embassy as channel for funds to health sector recovery through the Basic Package of Health Services and NGOs, and most notably the Sudan embassy that is (co-)chair or strategic partner in a number of national multi-donor trust funds or joint donor commissions and groups related to basic services, humanitarian aid and early recovery.

   The coordination of mandates, information and decisions of the Department of Health, Gender and Civil Society (DSI), the Fragile States and Peace building Unit (EFV) and the embassies in fragile states - e.g. The Department of Health, Gender and Civil Society (DSI) for the Co-financing System (MFS) and overall work programs with multi-national partners and embassies for country funds - requires streamlining. This should enhance coherence of approaches and strategies, and complementarity of expertise, partners and funding to support health recovery in Afghanistan, Burundi, DR Congo and Sudan. Current procedures do not yet seem to safeguard this.

Coordination between the Department of Health, Gender and Civil Society (DSI) of the Ministry of Foreign Affairs and the embassies of Afghanistan, Burundi, DR Congo and Sudan could be strengthened, particularly as some Dutch embassies are, on a number of occasions, playing an important role in donor coordination and health recovery processes.

8. Fragile state strategies and operational responses require complex and dynamic processes while calling for specialized skills from personnel involved. There is current commitment by the Ministry of Foreign Affairs to fragile state assistance, while the embassies have highlighted challenges in their capacity. Section 6.2 offers a number of capacity-building priorities and strategies to be considered, e.g. through the SPICAD program, through technical backstopping and by creating a pool of experts, including health (sector) experts able and available for Monitoring & Evaluation exercises.

   There is limited capacity in monitoring of activities that the Dutch administration financially supports but that are not part of the sector priorities. This should be an area of attention. It is recognized that external consultants may be able to carry out this monitoring role. The current development within the Ministry of Foreign Affairs/the Fragile States and Peace building Unit (EFV) to establish a pool of external specialists with fragile states experience can contribute to this. Technical experts (e.g. Platform/Fragile States Working Group) may be in a position to provide technical support e.g. by providing input into the development of a Terms of Reference for an evaluation mission in the health area. In addition, the Minstry of Foreign Affairs may want to explore the option of establishing more structural relations with Dutch resource centres.

The Ministry of Foreign Affairs could consider developing an ongoing Technical Assistance strategy for individual embassies in Afghanistan, Burundi, DR Congo and Sudan in collaboration with external specialists and platforms that are engaged in fragile states, maybe as part of a future 'knowledge circle on fragile states'. Health and health systems should be part of this expertise.

9. A number of Dutch-based NGOs are active in the health sector of Afghanistan, Burundi, DR Congo and Sudan. As described in section 7 and the appendices 1-4, the approach and focus of NGO support to early recovery in Afghanistan and Burundi seems to have moved beyond the humanitarian phase towards a more development-oriented approach. Sudan and DR Congo are clearly viewed as being in the early recovery phase: witnessing still large humanitarian medical aid programmes, albeit a growing number of health systems strengthening initiatives.

   NGOs are often engaged in: providing basic health care organization and coverage at local/district level; designing and implementing locally-adapted approaches aimed at community empowerment and improving accessibility and utilisation of care; performance-based financing etc. There are ample opportunities for cooperation and learning, e.g. by conducting operational or evaluation research, or being engaged in longitudinal studies

   There is extensive and on-the-ground expertise of Dutch NGOs in Afghanistan, Burundi, DR Congo and Sudan. This is an asset and the Dutch NGOs and the Minstry of Foreign Affairs should further explore practical avenues to improve communication and coordination at country level related to early recovery in the health sector (see section 7.2).

Dutch NGOs could invest more in opportunities for cooperation on formulating and implementing health recovery programs and projects in Afghanistan, Burundi, DR Congo and Sudan, and there

should be good cooperation with the Dutch administration on areas of mutual interest. Dutch NGOs should strengthen the position of research and (mutual) learning within their organizations.

10. Research has an important role to play (1) to assess the social determinants of health in fragile states; (2) to design and measure effectiveness of (multi-)sectoral strategies aiming to promote health; (3) to address the wider social, political and economic drivers of fragility and stability. There are a number of research questions with policy relevance as identified by international actors as well as by the Netherlands Platform for Global Health Policy and Health Systems Research. Some of these questions fit very well within the new global health policy and health systems research program prepared by the Platform and funded by the Ministry of Foreign Affairs and the Dutch Organization for Scientific Research NWO / WOTRO Science for Global Development (section 8).

Health recovery strategies in fragile states should be underpinned by high quality research. The Netherlands Platform for Global Health Policy and Health Systems Research has identified a number of pressing research needs. The new research program funded by the Ministry of Foreign Affairs and WOTRO Science for Global Development is an important vehicle to support such research and to build Dutch and local research capacity.

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1. INTRODUCTION

Since the UN Millennium Declaration, the Netherlands government has taken an active role in supporting the achievement of the Millennium Development Goals (MDGs). Sexual and reproductive health and rights (SRHR) of women and prevention and control of HIV/AIDS are already long-standing priories in Dutch development policy. More recent is the attention to delivery of basic services in fragile states in collaboration with Dutch development partner countries. This is not confined to the Netherlands alone, as the international community is increasingly concerned with the negative implications for stability and progress towards the MDGs resulting from state fragility. Fragile states are different from better performing countries in that they exhibit major development challenges such as weak governance, limited administrative capacity, chronic humanitarian crises, persistent social tensions, violence or the legacy of civil war.

In addition, sectoral challenges including fractured health systems, an overall vacuum in essential aid, and lack of effective coordination are a major barrier to reaching the health-related MDGs, with fragile states roughly accounting for:

- 1/3rd of people living in absolute poverty
- 60% of disease epidemics
- 1/3rd of maternal deaths
- 1/3rd of people living with HIV/AIDS in developing countries
- ½ of children dying before the age of 5
- Malarial death rate 13 times higher than in other developing countries[3].

Health services in conflict and post-conflict settings are largely ineffective, inefficient and inequitable. The failure of health systems to deliver and finance essential health services, attract and maintain an effective workforce, to work with local communities and to reach the poor and vulnerable populations is a major barrier to achieve progress towards the achievement of better health outcomes. The effects on women's health and MDG-5 appear to be particularly severe, as is shown by very poor access to reproductive health services and disproportionally high maternal mortality rates reported under those circumstances. Failing health systems also hamper socio-economic development at large, as there are tangible links between health systems, equity and wealth as noted by the reports of the high-level WHO Commissions on Social Determinants of Health[4], and Macro-Economics and Health[5].

It is within this context that the Division of Health and Aids (DSI/SB) of the Dutch Ministry of Foreign Affairs (MoFA) has asked the Netherlands Platform for Health Policy and Health Systems Research (Platform) the following question: "*Welke beleidsopties zijn er voor Nederland om binnen het kader van het algemene beleid gericht op fragiele staten, gezondheid te ondersteunen?*"

Earlier in 2008, the Platform produced a background document on international policies and evidence of health system interventions in fragile states, with special attention to SRHR/MDG 5 (Voortgangsrapport 1, Platform meeting June 2008). The document concludes that health is an important stability and development dimension in the context of fragile states. Progress towards the

[3] High Level Forum on Health MDGs, 2003

[4] WHO Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* WHO, 2008

[5] WHO Commission on Macro-Economics and Health. *Investing in health for economic development.* WHO, 2001

health-related MDGs is needed and possible even in these most difficult and complex situations and countries. However, this cannot be achieved without ensuring accessible and equitable delivery of basic services, as well as the strengthening of the country's health system. According to the international scientific literature, health sector recovery strategies should therefore aim, among others:

- To develop a coherent network of essential health care services in close cooperation with the local community and based on sound needs assessment;
- To ensure equitable access – financial, geographic and culturally acceptable - to essential health services;
- To promote good quality care, management, and infrastructure (buildings, equipment, staff, medicines, organization, (multi-disciplinary) care and treatment protocols, etc.);
- To be cost-effective and financially sustainable.

This requires the availability of important instruments and tools, such as good policy-making, information (systems), good research and good control. Effective policy-making in the health sector of fragile states deals with e.g.:

- establishing a good public-private mix in health service delivery and financing;
- establishing a good mix of horizontal and vertical programmes;
- establishing a good mix of care, infrastructure and inter-sectoral priorities aiming to promote health (e.g. building hospitals versus building hygiene and sewage systems);
- deciding about the right level and intensity of implementation (central, regional, local, community).

On the basis of this report and a well-attended discussion at the Platform's Annual Day of 9 October, conclusions were drawn regarding priorities as articulated in the November 2009 Platform's meeting. Meanwhile the Dutch policy context evolved rapidly by the publication of 2 policy memoranda in the field of fragile states and health in November 2008. As a response, MoFA and the Platform agreed to focus the advice on very practical possible next steps for development and synergy on the basis of the 'new' policy framework as well as operational strategies of the Dutch government/embassies and health interventions of Dutch NGOs in 4 partner countries classified as fragile states: Afghanistan, Burundi, DR Congo and Sudan. This report is the result of an analysis based on discussions with MoFA representatives and partner NGOs. It is aimed to stimulate discussion within MoFA as well as among the wider Dutch (development) community interested in promoting health in fragile states. The strategies contemplated in this report are not necessarily limited to ABCS as they are deemed applicable to many fragile settings.

Following an introduction, Section 2 of the report focuses in on Dutch policy framework on health and fragile states (2.1), and offers options for policy refinement, execution and synergy (2.2). Section 3 examines the importance of health recovery in fragile states on the basis of the current health situation and evidence related to the effectiveness of health interventions (3.1), and offers some policy options (3.2). Section 4 studies aid effectiveness to the health sector in fragile states, particularly related to the concept of early development (4.1), with related policy options (4.2).

Section 5 focuses on the situation in Afghanistan, Burundi, DR Congo and Sudan (ABCS); it describes the status of general poverty reduction and health strategies, and its general implications for assistance. In part 6, the Dutch engagement and ambitions related to health development are assessed in ABCS (6.1) and policy options are described (6.2). Section 7 examines the current country activities of 4 large Dutch humanitarian and development organizations (Artsen zonder Grenzen, Red Cross, Cordaid

and HealthNet TPO) in ABCS with policy options for NGOs and embassies in ABCS (7.2). The report ends with a discussion about the role of research concluding with a research agenda in section 8.

2. DUTCH POLICY FRAMEWORK ON FRAGILE STATES & HEALTH

2.1. International engagement in fragile states – case of Dutch policy

In 2007, the Cabinet Agenda 2015 and the policy memorandum "Our Common Concern" clearly placed the MDGs at the centre of Dutch efforts to support development in the South and called for an integrated 3-D approach (diplomacy, defence and development). Accordingly, the Netherlands committed itself to the agendas of security and development, with a focus on fragile states, and on equal rights and opportunities for women, emphasising MDGs 3 and 5. In November 2008 these policy priorities were operationalized in 2 separate policy memoranda on "Security and development in fragile states" (*Fragile States Strategy*) and the Policy Memorandum "Choices and Opportunities" on HIV/AIDS and SRHR in foreign policy (*HIV/AIDS & SRHR Memorandum*). In addition, the 2008 agenda for modernization of Dutch development assistance (International Cooperation 2.0) called for a more politically-oriented agenda, with ODA as a strategic tool to tackle urgent global problems.

Within the *Fragile States Strategy*, the 3-D approach is incorporated within the three dimensions of:

1. Improving the safety of civilians with attention to e.g. security sector reform;
2. Supporting a legitimate government with sufficient capacity through e.g. capacity building and enhancing political processes, and
3. Creating peace dividend. Health is not seen as an end-goal, but (re-)construction of health services is particularly viewed as a means of creating a peace dividend.

Creating peace dividends aims to show the population the advantages of peace and stability by offering improved living conditions and employment opportunities, hence reducing the source of conflicts and increasing support for stability. Emphasis is given to the concomitant delivery of short term tangible results as provided by humanitarian assistance and financing for longer term development objectives during the recovery to development phase. The Netherlands aims to put more emphasis on a multilateral approach and flexible funding to enhance this transition. Multi-donor trust funds (MDTF's) for social-economic development are seen as the key investment strategy for building of social services in the medium- to long-term. The social-economic programmes in fragile states should furthermore pay attention to equal rights for women and SRHR, which accords with funding to UNFPA. In addition, attention to human rights and the needs of vulnerable populations manifests through programmes of civil organizations, for example Dutch support for delivery of basic services through NGO's, particularly during the transitional phase from humanitarian assistance to sustainable development. Strategic cooperation with NGOs through the so-called Medefinancieringsstelsel (MFS) and the Strategic Alliance International Organisations (SALIN) will become more focused on fragile states.

The 2007 OECD/DAC *principles for good international engagement in fragile states and situations* are to enhance the design of an effective approach to working in fragile states. Consequently, the Dutch policy for engagement in fragile states promotes local ownership; emphasizes the context specificity of each situation; commits to flexible and long-term engagement; utilises multi-lateral

approaches where possible to enhance effectiveness but bilateral where needed; and focuses on conflict prevention. The Netherlands endeavours to achieve these aims by working in an integrated way through a "Whole of Government approach". The shift in policy attention to fragile states and the way of working has newfound implications for expertise and capacity requirements. Establishing the Fragile States and Peacebuilding Unit (*EFV: Eenheid Fragiliteit en Vredesopbouw*) at MoFA to coordinate and support the Dutch deployment in fragile states, creating a central "pool of civil experts", and faster and more flexible deployment of people and resources at the Dutch Embassies are some recent or intended measures.

Tackling human rights abuses in relation to HIV/AIDS and SRHR, and substantially increasing access to preventive measures are the leading priorities in the *HIV/AIDS & SRHR Memorandum*. Strengthening political leadership; reinforcing the role and position of women; improving health systems; engaging the public and private sectors; and cooperation between the different actors are seen as conditions for reaching these objectives. Challenges identified are:

- the violation of rights;
- neglect of the facts;
- insufficient investments in general healthcare;
- insufficient planning and good cooperation between public and private care providers;
- limited availability of reproductive health commodities;
- insufficient efforts outside the healthcare sector;
- sustained technical and financial support

Advocating for human rights, building bridges, acting as knowledge broker, and being an important funder of international organizations and NGOs are seen as Dutch added value. Therefore, efforts are focused on access to prevention and rights in relation to sexuality and procreation, raising political commitment (Cairo-agenda, position of women, reducing maternal deaths and stigma of HIV/AIDS)[6] and a multi-sectoral approach (good governance[7], social economic development, education, health).
The Dutch efforts differ per country and per sector, depending on the available capacity and the agreements on task division between UN-organisations and donors.

The *HIV/AIDS and SRHR Policy Memorandum* acknowledges the problems in conflict situations and fragile states: sexual violence, maternal and child deaths, non-functioning health systems and disrupted health services, with high shortages of personnel and medicines and problems in referral to hospital care due to insecurity and destroyed infrastructure. The Memorandum does not specifically attend to operational plans for fragile states but does point to a number of integrated instruments for SRHR and HIV/AIDS in conflict situations and humanitarian aid, such as advocacy, reform and training of the security sector, support to UNFPA, NGOs for anti-conception, medical support for victims of sexual violence, support to public-private partnerships for Research & Development of new preventive means, and support to education.

At a meeting on 2 April 2009 marking the presentation of the book and the first anniversary of the conference "Knowledge on the move", Minister Koenders indicated the importance of establishing

[6] Women are acknowledged as playing important roles in peacebuilding and in sustaining security on a communal level while gender inequality is perceived to inhibit development, cited in Bastick, M (2008), Integrating Gender in Post-Conflict Security Sector Reform.

[7] According to Reynal-Querol (European Journal of Political Economy, 21, 445-465, 2005), inclusiveness in a political system, i.e.a multi-party system, is more important than democracy per se.

knowledge circles (*kenniskringen*) around the 4 strategic areas of the policy memorandum "Our Common Concern", among which are fragile states and gender/SRHR. In fact, the *Netherlands Platform for Global Health Policy and Health Systems Research*, which brings together leading academics, practitioners and policy-makers around a mandate that includes policy advice and making evidence and knowledge available to policy-makers, has been functioning as such a knowledge circle 'avant la lettre'. An evaluation of its role and performance in policy advice was made upon the request of DSI/SB by the Platform in March 2009 and the results of this exercise are available to DSI/SB.

2.2. Policy options

1. An integrated approach to SRHR and HIV/AIDS, other public health priorities and health system strengthening is still nascent in the Dutch foreign policy. In general we believe that more attention could be paid to health systems as primary policy goals next to the health-related MDG-targets.

2. The Netherlands provides significant financial support to multilateral organisations (UNFPA, UNAIDS, GFATM) to support the fight against HIV/AIDS and to address violations of SRHR. However, the effectiveness of multilateral organisations is often constrained in fragile states where the situation is complex and capacity is limited to deal with the overwhelming needs, while financial management capacity is insufficient to implement the often complex procedures. The Netherlands is in a unique position to stimulate the multilateral organisations to adopt financial management procedures that are fit for the capacity and context of each setting. Also, the Netherlands should advocate for adequate technical support to ensure funds will be available and used effectively in fragile states where support to HIV/AIDS and SRHR and links with wider health systems strengthening is much needed.

3. Strengthening the interconnectedness between security, economic development, health and education is critical in post conflict states. MoFA implementation of the policy for fragile states should take account of the role of women leaders and women participants in connecting local communities to government. The role of women in facilitating dialogue between policy makers, politicians and community members to address issues such as the high incidence of violence against women and related reproductive health and rights should be explicitly supported.

4. MoFA added value in advocating for the mainstreaming of HIV/AIDS and gender in fragile states should not be underestimated. The Netherlands actively supports multilateral organizations, such as UNFPA and the World Bank, to promote the multi-sectoral approach. Yet, opportunities to promote mainstreaming of SRHR and public health priorities through the bilateral cooperation channels are underutilized. Dutch embassies can encourage ministries to support a more comprehensive and multi-sectoral response to SRHR and pubic health and could provide a platform for dialogue of different partners, including local NGOs that are supported through MFS and SALIN.

5. The role of health and the health sector in the 3D approach promoted in fragile states is not well articulated. Evaluations to learn lessons about the effectiveness of the 3D approach promoted in fragile states, specifically in relation to the support to the health sector, is recommended to ensure

the Dutch strategies achieve its aims of enhancing peace and preventing conflict AND progressing on attainment of the MDGs[8].

6. Now that the strategic directions for engagement in fragile states and SRHR & HIV/AIDS are set, it is timely for EFV and DSI to step-up the communication and coordination to further strengthen the links between health, development and security. There are still important questions requiring debate:

(i) How can a balance be achieved between alignment with country strategies and multi-lateral engagement (Paris and Accra agenda) and the importance given by the Dutch to provide 'added value' and support to difficult or controversial issues, such as abortion services.

(ii) Should resources at individual country level to a large extent be channelled through multi-donor trust funds or basic package approaches or should a significant amount be reserved for additional priorities and projects?

(iii) What are the information needs of the Dutch government and administration?

(iv) What is the role of evidence in relation to strategic goals and development aid related to the health sector of fragile states, and in which way does this influence the research agenda?

(v) What exactly can be expected from the mandate and expertise of multi-lateral organizations such as WHO, World Bank, UNFPA, UNAIDS, GFATM, ICM when it comes to providing basic services and strengthening health systems in fragile states?

The Health Systems Platform could help to facilitate and/or provide input into these discussions, e.g. by organizing focused 'seminars' with policy-makers and experts within and outside the MoFA.

7. Creating a pool of experts is a way that ensures fast and flexible access to new expertise and capacity that is otherwise not available in the administration. Given the limited personnel capacities at central and embassy level in fragile states, health and health systems expertise should be among the relevant areas to be ensured within the human resource pool that is currently being established by EFV.

8. Within the Platform's own evaluation, there are important lessons to be drawn about the set-up, role and functioning of *knowledge circles (kenniskringen)* as anticipated by MoFA. In general, it can be an effective tool to make knowledge and evidence available for the purpose of policy-making. However, it does have financial and human resource (time and attention) implications also on the side of MoFA.

9. The Platform encourages MoFA to include health and health systems expertise within both the Fragile States and Gender/SRHR knowledge circles, when being established.

[8] Health and nutritional indicators per se are important determinants of conflict onset and fragility. According to Pinstrup-Andersen & Shimokawa (Food policy, 33, 513-520, 2008), achieving MDGs, pro-poor policies, and prioritization of agriculture and health will contribute to reducing the risk of armed conflict.

3. IMPORTANCE OF HEALTH RECOVERY IN FRAGILE STATES

Table 1: MDG-5 related indicators in ABCS

	Life expect. at birth men	Life expect. at birth women	Total fertility rate	Maternal mortality (MM) per 100.000	Life-time risk MM
Afghanistan	42	43	7.2	1800	1 in 7
Burundi	48	50	6.8	1100	1 in 12
DR Congo	46	49	6.7	1100-1300	1 in 10-12
Sudan	59	61	4.5	450 – 2048	1 in 10-45

3.1. Current status of health indicators in MoFA priority countries

As an indication of the general poor health status of their populations (see Table 1), life expectancy at birth, fertility rates and maternal mortality ratios in ABCS, being among the most conflict-sensitive Dutch partner countries, are among the worst globally.

Why is this the case, and why is there such a shortfall in reaching the MDGs in these contexts? Naturally, conflict and/or violence, social inequity, poverty and hunger are the most important determinants. However, part of the reason is also that, in fragile states, delivery and scaling up of health services is more difficult than other low-income settings due to poorer governance, severe human resource and financial constraints, and extra problems in access to essential services faced by the local population. Resource constraints are further exacerbated both by a contested policy environment and a reliance on international aid, which results in extreme volatile funding. It also makes harmonization and alignment more challenging to the detriment of aid effectiveness.

The health sector in fragile states faces multiple challenges, with the aim of:

- Meeting the immediate health needs of conflict-affected populations;
- Restoring essential health services;
- Rehabilitating the health system.

Again as an illustration, Table 2 summarizes some health system indicators related to MDG-5 for Afghanistan, Burundi, DR Congo and Sudan. The figures show a large discrepancy in the most conflict-sensitive societies towards the goal of universal access to reproductive health by 2015, as evidenced by the very low prevalence of contraceptive use and low proportion of births attended by skilled personnel. There are no comparable statistics available for unmet need for family planning and availability of emergency obstetric care services, but secondary data sources also indicate significant gaps in such service delivery.

Table 2: MDG-5 related health system indicators in ABCS

	Prevalence (%) contraceptive use	Antenatal care coverage (%)	Births attended by skilled personnel (%)
Afghanistan	10-36	50-90	14-16
Burundi	20	93	34
DR Congo	30	72	60
Sudan	7	75	49-68

Meeting immediate health needs falls at the core of humanitarian and complex emergency crisis response. As experience demonstrates, interventions call for rapid ramp-up, urgent infusion of resources and capacity, and concrete results as the provision of health (along with other social services) is one of the critical demonstrations to the transition to peace. After the urgent crisis for conflict-affected populations has been addressed, the assistance shifts to designing a cost-effective package of basic services, setting priorities (e.g. getting services to marginalized and/or underserved groups, targeting at-risk populations) and establishing delivery mechanisms. From investments and assistance to restore essential services the need for institution building for the health system is revealed. Health governance furthermore surfaces as a concern as the public health system, as a component of the state, needs to develop legitimacy in the eyes of citizens and be seen as effective, responsive and accountable. Capacity building of the health system is vital to enable public health actors to prepare budgets and plans, administer grants and contracts, manage human resources and facilities, handle medicines and equipment logistics, etc.

A recent publication of the Health & Fragile States Network[9] concludes that policies in fragile states to address health inequities should be multi-sectoral and include strategies to address fundamental social determinants of health, especially nutrition, water, sanitation and basic education. Conflicts in themselves are social determinants of health. The important underlying question is not how health programs are implemented rather how the health sector (together with safe water, food and sanitation) can contribute to identifying and resolving the political, social and even economic drivers of fragility within a given country or region.

Equity should be a core principle of the health policy framework, which is to be developed rapidly in the early recovery phase. In support of this, building in-country capacity in key policy and planning areas should begin as soon as possible after the conflict has ended. Technical assistance is required to support a number of strategic and operational priority processes aiming to start building the government's capacity as a health sector steward. A rapid roll-out of a basic package of curative and preventative services, made universally available should be the primary strategy to reduce inequities and ensure geographic coverage. External aid is critical, as funding for a basic package of services is highly dependent on aligned and harmonized donor support, and delivery of basic health services is

[9] The Health and Fragile States Network was created in October 2007 by a group of interested agencies and donors. The aim is to stimulate the policy and research agenda around how best organize and finance health services in these environments. The secretariat is hosted at the Conflict and Health Programme at the London School of Hygiene and Tropical Medicine.

often largely dependent on international and local NGOs. An increasingly popular approach is towards public-private partnerships whereby donors and country health ministries contract out service delivery to private providers as is being done in Afghanistan, Southern Sudan and DR Congo.

3.2 Policy options

1. Achieving the MDG's will entail significant support to fragile states, as these (post)- conflict countries are amongst the worst achievers. However, this cannot be achieved without ensuring accessible and equitable delivery of basic services, especially reproductive health services, as well as the strengthening of the complete health system. The Netherlands can support the basic health package approach in fragile states, which should be based on an adequate health needs assessment. The Netherlands could pay special attention to inclusion of comprehensive reproductive health services (including, reproductive rights and choices) within the basic health packages designed for fragile states.

2. While major inequities exist in access to essential services in fragile states, strategies to address such deficits can only be achieved through a comprehensive package of health services that also addresses the wider determinants of health (education, nutrition, water and sanitation). MoFA therefore should advocate for priority to poverty reduction strategies through a multi-sectoral response including an appropriate mix of public and private sectors and resources. It also requires complementarity with other donors and avoiding duplication of funding within and across sectors.

4. IMPROVING DEVELOPMENT EFFECTIVENESS IN FRAGILE STATES' HEALTH SECTORS

4.1. Choice of aid mechanisms in recovery of the health sector

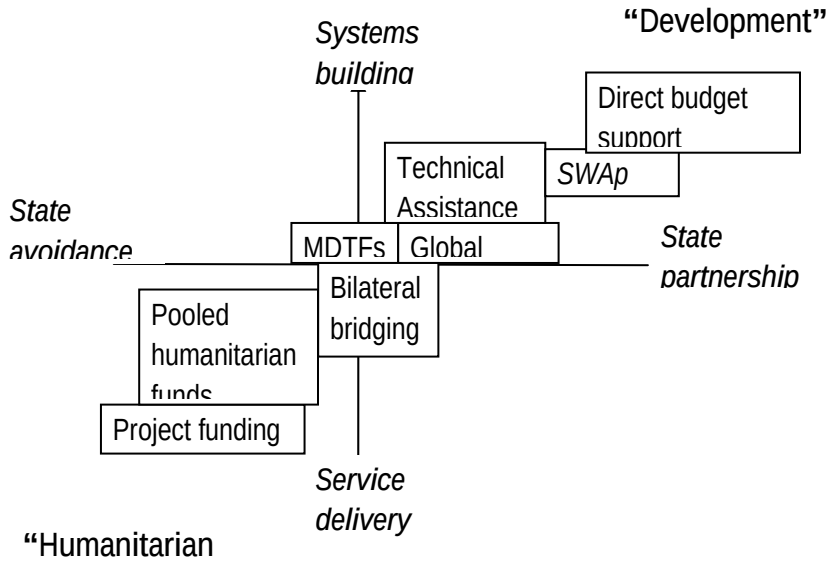
Since the signing of the Paris Declaration in 2005, enhancing aid and development effectiveness has played an increasingly central role in the international development arena. The Declaration promotes the use of aid effectiveness principles such as ownership, alignment, harmonisation, mutual accountability and managing for results (OECD DAC, 2005c). A more recent impetus towards this goal is derived from the "Third High Level Forum on Aid Effectiveness" held in Accra in September 2008. The Netherlands Fragile States Strategy was seen to strongly support these aid and development effectiveness principles.

Building on the agreed principles of aid effectiveness for the health sector, the International Health Partnership (IHP)[10] was established in September 2007 with the aim to work towards the achievement of the Millennium Development Goals (MDG's), through the strengthening of national health systems and improved health results. The Netherlands politically supports the IHP.

[10] International Health Partnership Launch, September 05, 2007 - with initial funding from DFID and NORAD.

The *Fragile States Strategy* furthermore recognises the importance of the transition from relief to development, which is also applicable to health. In fact, this transition is especially crucial in the health sector where continued service delivery is required concurrent with health system strengthening. However, donor support usually follows a more linear continuum; with aid mechanisms progressively advancing from a humanitarian approach which is more state-avoiding in nature, through supporting NGO's to ensure service delivery, to a developmental approach promoting state-partnership and health system strengthening.

Figure 1: Characteristics of aid modalities



As illustrated in Figure 1, there is an array of aid mechanisms available in fragile states which can be classified as more humanitarian or more development in their approach. Each of these mechanisms has their own strength and weaknesses[11]. In summary, it can be seen that aid mechanisms vary in relation to the extent they are partnering with the state or in fact avoiding the state. Similarly, the activities supported through the implementation of such modalities range on the spectrum between service delivery and health systems building.

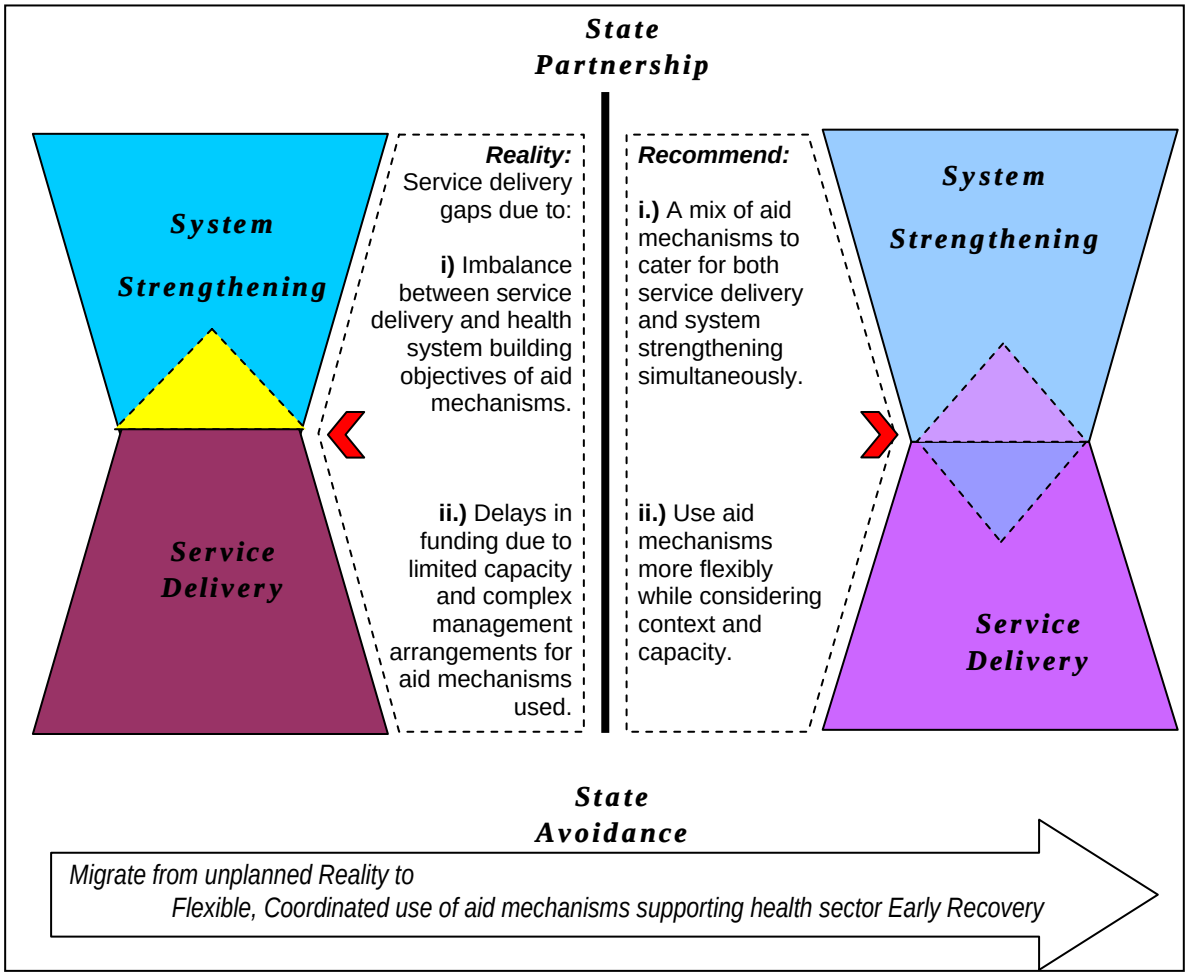
A recent study (Vergeer, Canavan, et al, 2008) on the use of selective aid mechanisms in different fragile states found that these often contradictory objectives were found to be difficult to attain through the use of a single aid mechanism. Modalities that foster state partnership and system building, like budget support or MDTF, can work in fragile states if they consider particular circumstances and the relative low capacity. The complexity of some of the aid mechanisms used and the limitations to available capacity to implement them saw a (potential) disruption to the service delivery in several countries. As an example, Afghanistan (-19%) and Burundi (-86%) witnessed reduction in aid allocations for maternal health in the post-conflict stage despite pledges and needs.

[11] For a full description of aid mechanisms we refer to the November 2008 Platform document and to Canavan, A., Vergeer, P., Bornemisza, O. (October 2008), *Post-conflict Health Sectors: The Myth and Reality of Transitional Funding Gaps,* Commissioned by the Health and Fragile States Network. Completed in Collaboration with the Royal Tropical Institute…

Establishment of interim or substitute aid mechanisms to respond to anticipated or real gaps in service delivery usually occurred 'ad hoc' and unplanned, as illustrated by the *Reality* portrayed in Figure 2.

For that reason, the former practice of progressively advancing from aid mechanisms which focus primarily on health service delivery and are state avoiding in nature, to those which are partnering with the state to strengthen the health system, requires rethinking. Instead a paradigm shift is required, as *Recommended* in Figure 1, which allows for an integrated mix and sequencing of modalities used to balance the multiplicity of objectives (state, non-state, systems building, service delivery) in early recovery settings. Better harmonisation and coordination of the use and complementarity of different aid instruments is called for (as now often ad hoc) to deal with delays and overcome gaps in health service delivery that are a result of how aid instruments are used. This should ensure that health service coverage for the vulnerable populations is maintained while simultaneously the health system is being (re)built. Furthermore, there is scope for donors at country level to discuss and agree who is best positioned to support which activity to cover the multiplicity of objectives apparent in the health sector during the early recovery phase.

Figure 1: Paradigm shift to improve aid effectiveness to the health sector[12]



[12] Copied from: Vergeer, P. Canavan, A. Rothman, I. (2008), *A rethink of the use of aid mechanisms for the Health Sector in Early Recovery.* KIT Development Policy & Practice

4.2. Policy options

1. The Netherlands as significant donor to multi-donor trust funds and international organisations is well placed to advocate for enhanced development effectiveness in the health sector of fragile states through the promotion of strategies recommended in Figure 1. In addition, the embassies in fragile states are able to advocate for coordinated donor support at country level.

2. The Netherlands continued support to the IHP+ is important. Monitoring its results and potential applicability in fragile states settings is recommended

5. HEALTH RECOVERY STRATEGIES IN AFGHANISTAN, BURUNDI, DR CONGO AND SUDAN

5.1. Development and implementation of locally defined health recovery strategies

Afghanistan, Burundi, DR Congo, Sudan each have a government backed and up-to-date overall strategic framework in place for the health sector, such as a Poverty Reduction Strategy or health sector strategy. More equitable health systems, better functioning basic health services that target the poor and vulnerable populations, attention to gender issues and local health priorities are typically identified as strategic objectives requiring action. In all cases, context specific strategies are developed with the support of various UN agencies, the World Bank, the EU and bilateral donors and private foundations. In addition, country-level specific HIV/AIDS and/or reproductive health strategies and policies are also in place.

Funding for poverty reduction strategies and health strategies in fragile states will be reliant on substantial external donor support due to economic collapse and inability of the public sector to raise resources, while user fees should not be relied upon due to the impoverishment of the population.

However, it is here where the main challenge lies, as *implementation* of these strategies is usually only partial due to severe underfunding. Next to financing problems, there are also usually gaps in the service package defined. The main gaps highlighted in a comprehensive review of the BPHS are services addressing sexual and gender based violence, despite ample evidence of the high rates of violence during and after conflict as noted in DR Congo and Southern Sudan. Equally mental health services are not included in some countries where the needs are greatest in such post conflict settings. It is here where there may be an opportunity for Dutch support, though multilateral, bi-lateral and NGO channels, as described in the following strategies for consideration.

5.2. Policy options

1. The implementation of locally defined health sector strategies in ABCS is important to contribute to early recovery and the achievement of the MDG's. Even if these are not health partner countries, the Netherlands should consider the provision of financial contributions in support of these local strategies, most often through support of the BPHS. Alternatively, it may advocate with the multilateral organisation it supports or for other donors to take on this responsibility.

2. In fragile states where the Netherlands is engaged in the health sector, e.g. in Afghanistan, opportunities exist to promote an equitable, accessible health system which is inclusive of essential services, like reproductive and mental health, and gender mainstreaming. First of all, The Netherlands could make a difference to analyze needs and gaps in accessibility and coverage. This would help to better targeting country-level reproductive health interventions and donor support strategies. The MoFA should continue to take a pro-active role to raise awareness and mobilize other donors through diplomatic and other efforts. Especially now, as there is a window of opportunity opening for renewed discussion on some controversial issues (notably related to sexual health and abortion) due to the change in the USA's leadership. Finally, The Netherlands should continue to support NGOs to fill gaps in service provision and community empowerment strategies.

6. HEALTH FOCUS IN MULTI-YEAR STRATEGIC PLANS 2008-2010/11 FOR ABCS

6.1. Country status of MYSPs – an overview

The Dutch government has embassies in ABCS with core diplomatic and consular capacities and duties, and these embassies each have developed a Multi-Year Strategic Plan (MYSP) for the period 2008-2010/11. The position of health in these MYSPs is examined in terms of policy choices, financial resources and capacities.

At *strategic (target) level*, in all countries the main focus is on the security sector, good governance and promotion of human rights so as to contribute to peace. Contributing to an enabling environment to achieve the MDG's is mentioned as well. The strategic position of health as development objective and element of peace dividend is not always visible. Afghanistan has an explicit target related to health care (target 5), which is defined in terms of access to basic health services and improvements in women's voice and rights in relation to reproductive health care. The embassy's role is to support the execution of national programs and expansion of available health services in the province Uruzgan, as well as the improvement of the quality of these services on the basis of initiatives of the health authorities and NGOs. In relation to SRHR the embassy stimulates the attention to reproductive health within the Afghan government as well as mainstreaming in its own and national programs. Sudan gives importance to supporting the transition of humanitarian assistance to recovery and development, advocating for MDG-related issues – notably HIV/AIDS and role of the woman – in national policies and the provision of basic services to the whole population (with particular focus on South-Sudan as geographic target area), the latter without specific mentioning of health and healthcare. Burundi highlights the need for increased attention to Gender Based Violence (GBV) as part of the strategic focus on security sector reform (SSR). DR Congo pursues the improved role of women and a reduction in GBV as a priority with attention to protection and sensitisation for GBV also written into the security sector, good governance and human rights as well as socio-economic reconstruction highlighting the need for advocacy and mainstreaming of gender.

At *resource level*, Afghanistan has earmarked 1 m€ annually for support to the Basic Package of Health Services in Uruzgan, as well as contributions to Dutch NGOs in Uruzgan related to health and education (undefined, in the region of 2-3 m€ annually total).

Sudan funding is mainly spent through national and regional multi-donor trust funds for longer term development while maintaining continued support to humanitarian activities through e.g. the Common Humanitarian Fund. There is no earmarked funding for health.

DR Congo reserves 1.5 m€ annually for good governance and human rights. This includes funds for medical care for women affected by sexual violence in east-DRC (Goma hospital).

Burundi earmarks 13 m€ annually for budget support – through a World Bank operated trust fund - which includes salary support to social service providers among which health care personnel (unspecified amount).

All in all, the relatively low priority given to health recovery in most MYSPs as opposed to the security and human rights agenda is reflected into limited and/or invisible (earmarked) bi-lateral resources available for the health sector of ABCS.

None of the ABCS are health-partner countries so none of the embassies employ a health sector specialist. The organization and staff deployment at embassy level means that essential diplomatic tasks, such as high-level agreements and advocacy for health system recovery, are in principle covered but that the operational capabilities to play a (pro-) active and significant role in the health arena are limited. However, the embassies sometimes have important roles to play, for example the DRC embassy as co-secretariat of the Working Group Sexual Violence, the Afghanistan embassy as channel for funds to health sector recovery through the Basic Package of Health Services and NGOs, and most notably the Sudan embassy that is (co-)chair or strategic partner in a number of national multi-donor trust funds or joint donor commissions and groups related to basic services, humanitarian aid and early recovery. Most embassies highlight the need to improve the monitoring of activities they fund, if necessary with the support of external consultants.

6.2 Policy options

1. The coordination of mandates, information and decisions of DSI and the embassies in fragile states - e.g. DSI for MFS and overall work programs with multi-national partners and embassies for country funds in MYSPs - requires streamlining to ensure coherence of approaches and strategies, and complementarity of expertise, partners and funding to support health recovery in ABCS. Current procedures do not yet seem to safeguard this..

2. Many governments and UN and donor agencies have emphasized women's participation and efforts to achieve gender equality as crucial elements of post-conflict reconstruction. At a strategic level, opportunities exist for gender mainstreaming in the embassies own activities or advocating for this in government strategies. The promotion of gender mainstreaming in the security sector or sectors like education can be capitalized so as to improve the role of women and reduce GBV. Engagements with government and with multilateral organizations create other avenues.

3. Over the past two decades HIV has shifted from a health sector issue alone to an overall development problem with responsibilities moving from only the health sector to the need for multi-sector stakeholder involvement. Evidence has shown such an approach is required to contribute to the enabling environment for achieving the HIV-related MDG. It is known that

economic development can contribute to increased HIV risks. In line with the Dutch policy it is recommended that the Netherlands embassies should, at country level, contribute to and promote these multi-sectoral approaches as well as mainstreaming of activities supported sectorally.

4. The transition from relief to development assistance has been highlighted as crucial in most of the embassy plans. Consideration for the complementarity and harmonization of aid mechanisms is recommended, as described in section 4. The embassies can play a contributing role at country level to ensure that the different aid mechanisms and their financial procedures are well-adapted to the specific country context and capacities.

5. Fragile state strategies and operational responses require complex and dynamic processes while calling for specialized skills from personnel involved. There is current commitment by MoFA to fragile state assistance, while the embassies have highlighted challenges in their capacity. Consideration is therefore to be given how the capacity of the embassies can be strengthened in relation to e.g. gender- and HIV mainstreaming or aid effectiveness to facilitate the transition from relief to development. A program designed to address capacity gaps of staff for the current priority country portfolio of ABCS could be designed and may be of benefit to embassy staff. Appropriate ways of capacity building are to be explored; one avenue may be the Support Programme for Institutional and Capacity Development (SPICAD) which is managed by the Royal Tropical Institute (KIT) and Wageningen International. Currently SPICAD is to enhance the existing capacities of embassy staff to support their partners in addressing institutional and capacity development challenges in stable country contexts but could potentially be extended and tailored to fragile state contexts.

6. In addition to the uptake of coaching, virtual learning and workshops by embassy and other MoFA staff, the specific knowledge and information needs can also be supported through technical backstopping from external experts with extensive expertise in the area of policy, planning and implementation of health interventions in post-conflict reconstruction and recovery settings.

7. The limited M&E capacity for activities that are financially supported by the Dutch administration but that are not part of the sector priorities should receive attention. MoFA may want to consider developing an ongoing TA strategy in collaboration with external specialists and platforms that are engaged in fragile states. It is recognized that external consultants may be able to carry out this monitoring role and the current development within MoFA of a pool of external specialists with fragile states experience can contribute to this. Technical experts (eg, Platform/Fragile States Working Group) may be in a position to provide technical support e.g. input into the development of a TOR for an evaluation mission. In addition, MoFA may want to explore the option of establishing more structural relations with Dutch resource centres.

7. ENGAGEMENT OF DUTCH NGOS TO MOFA PRIORITY COUNTRIES

7.1. From humanitarian relief to development – role of NGOs

The support strategies of Dutch NGOs working in ABCS are studied by examining country coverage, goals/projects, scope/activities and financing of 4 large Dutch-based humanitarian medical aid and

health-sector oriented development organizations: the Red Cross NL, Artsen zonder Grenzen NL (AZG- NL), Cordaid and HealthnetTPO in ABCS. A summary of the NGO support provided can be found in *Annexes 1-4.*

The first observation is that the approach and focus of support to early recovery in Afghanistan and Burundi seems to have moved beyond the humanitarian phase towards a more development-oriented approach. HealthNet TPO and Cordaid are scaling-up while Red Cross – NL and AZG- NL have closed down their direct programs. Interestingly, for Red Cross – NL this is at least partly due to a change in the funding mechanism (through country government as purchaser of basic services) that cannot be combined with the organization's neutral mandate. Sudan and DR Congo are clearly viewed as being in the early recovery phase: witnessing still large humanitarian medical aid programmes, albeit a growing number of health systems strengthening initiatives. From a population health perspective the health and health systems indicators in all the four countries (see pages 6-7) are almost equally alarming - thus still warranting significant longer-term focus and resources across the relief to development spectrum in all four countries. Given the vast needs, it poses the question whether health should not receive a more prominent position on the agenda for fragile states & early recovery?

A second observation is the opportunities for *coordination***,** operational research and learning among NGO's. In fact, many health sector NGOs – not only Cordaid or HealthNet TPO – implement programmes aimed at Primary Health Care organization and coverage at local/district level, community approaches aimed at strengthening empowerment and accessibility and utilisation of care, performance-based financing etc. These programs require professional, evidence-based and context-sensitive approaches and resources, particularly in fragile contexts. NGOs have a critical role to play in the early recovery phase while faced with the limitation that donors' agendas are more and more focussed on outputs and results. NGOs have a common interest to test and verify what works and what doesn't, and build trust and credibility for health as an important aspect of early recovery and peace dividend. To date, NGO's engagement in research - operational research, evaluation research and longitudinal studies - is limited.

Dutch NGOs working in ABCS reported barriers in communications and coordination with embassies due to the limited capacity and attention of embassies to health issues. Some NGOs note that the enlarged policy attention as written down in the Fragile States Strategy may have led to increased difficulty in accessing embassies in ABCS due to the many more duties placed on them as well as the domination of security and government legitimacy issues. Donor task division can, at best, only partly replace this.

7.2 Policy options

1. There is extensive engagement and on-the-ground expertise of Dutch humanitarian aid and development partners in the health and development sector of particularly South Sudan and East DRC, but also in Afghanistan and Burundi and, indeed, the other fragile partner countries. This is an asset and the Platform advises including or strengthening the health expertise in the multi-sectoral country teams to refine and implement 3-D strategies, as envisaged in the *Fragile States Memorandum* (page 15). It would furthermore help the dialogue between health and other sectors and support the understanding and further refinement of strategies to promote health as an important peace dividend.

2. The Dutch NGO humanitarian aid and development community as well as the MoFA could explore practical avenues to improve communication and coordination at country level related to early recovery in the health sector in (a) selected Dutch (fragile) partner country/ies. Guaranteeing access and right to basic health care to the local population, as well as to avert a possible transitional funding gap and worsening health indicators in the early recovery phase is an objective the different actors share. The role of the Dutch administration could be to offer a platform for planning coordination at country level (through the Embassy), act as advocate for solutions and for transitional and development funding in multi-donor settings and/or operate as transitional funder in the short-term through (de)centralized funding mechanisms until a more stable service delivery and funding mechanisms is in place for the development phase (e.g. joint donor trust fund, basic package of health services etc.). This would be innovative internationally as well as a very practical example where Dutch government and NGO humanitarian aid and development partners could make a difference and set an example at local level.

3. Dutch NGOs could invest more in opportunities for cooperation on formulating and implementing health recovery programs and projects in ABCS. Dutch NGOs should strengthen the position of research and (mutual) learning within their organisations

8. DISCUSSION ON THE ROLE OF RESEARCH AND THE LINK TO THE RESEARCH AGENDA

Research has an important role to play to assess the social determinants of health in fragile states and to design and measure effectiveness of sectoral and multi-sector strategies aiming to promote health and/or addressing the wider social, political and economic drivers of fragility. Both formal and action-based research are therefore needed. At the Annual Day of the Netherlands Platform for Global Health Policy and Health Systems Research, held on 9 October 2008, participants from science, policy-making and development practice suggested the following priority questions, requiring further research, related to health recovery in fragile states:

1. How to build essential health packages with/in fragile states, on what grounds select interventions for inclusion and what are the relation to cost and financial sustainability, cost-effectiveness of interventions, equity and empowerment?
2. How to finance and organize scaling-up of essential health packages at macro-level (aid modalities, financing and contracting mechanisms) and how to ensure performance of organizations responsible for/ contracted to provide services (payment methods, incentives)?
3. How best to align and harmonize donor support (including NGO's) to the health sector, what are effective interfaces between countries and the donor community, in the short- and medium/longer-term?
4. How do we increase accessibility to reproductive health services in underserved areas (slums, rural areas), what is the role of local health beliefs in relation to demand and care-seeking behavior and how to ensure an effective continuum of care?
5. What are best practices to mobilize, train and retain midwives and other health workers on a significant scale and what are the barriers to implementation, how can they be overcome?

6. How to measure effects of multi-sectoral interventions, 3-D interventions, and effects of health systems on wider political, economic and social drivers of fragility? How to ensure that evidence is used widely in policy- and decision-making?

These topics align well with the research program proposed by the Netherlands Platform for Global Health Policy and Health Systems Research which has as a strategic aim; “equitable access to quality health systems”. If the Dutch government aims to play an active and longer-term role in fragile states, including MDGS, it should recognize the importance of research and evidence-gathering to underpin the policy agenda and collective learning and thus commit resources for Dutch and international research efforts. Finally, a plea was made to devote appropriate attention and resources to data collection, monitoring and evaluation *as an integral part* of future interventions initiated or supported by the Dutch government.

Annex 1: AFGHANISTAN[13]

Organization	Goals/projects	Scope/activities	Financing
Cordaid (mainly through AHDS, Ibn Sina, HealthNet TPO)	Basic health care provision to general population and vulnerable groups	- Implementing the BPHS in Uruzgan (AHDS) - Providing mental health as part of the BPHS in Laghman and Nangarhar - Healthcare to IDPs through mobile clinics in camps around Kabul	2 m€ annually, of which 600.000€ MoFA (MFS): basic health care in Uruzgan (through EU, also Embassy Funds), mental health, public health training institute, training and TA and care for the handicapped
	Health systems strengthening	- Training to MoPH staff - Support Afghan NGO to establish Institute for Public Health and Management Sciences in Kabul - - Financing education of nurses and midwives at the Kandahar Institute for Health Sciences	
HealthNet TPO	Basic health services provision to the general population and vulnerable groups	- BPHS provision in Nangarhar and Khost provinces (1 million population)	Appr. 7.5 m€ annually, of which appr. 55.000€ annually from MoFA for additions BPHS in Uruzgan (2007-2008) and 180.000 for inception phase DCU II in 2008
	Disease-management programs	- Implementing the national Malaria Control Programme, Global Fund	
	Health systems strengthening	- Linked to the delivery of the BPHS are health systems strengthening elements such as community participation, community midwifery training, performance-based financing, cost-sharing, management support and policy development	
	Mental health programme	- Mental health policy development, training, community-based psychosocial services, and integration of activities in the basic health care system	

[13] The NL Red Cross until recently also provided humanitarian assistance in Afghanistan (through MoFA financing) and support to the Afghan Red Cresent. Structural financing discontinued. AZG-NL programme in Afghanistan also stopped.

Annex 2: BURUNDI

Organization	Goals/projects	Scope/activities	Financing
Cordaid	Basic health services provision to general provision Health systems strengthening	- Financing the delivery of basic health services in hospitals and posts in 4 districts and from 2009 through execution of Sante+ program of the Government and donors (mainly EU) in 6 provinces - Performance based financing (PBF) of basic health services in 7 provinces. - Pilot HIV/AIDS prevention, home-care of HIV/AIDS patients and its integration with the health system through PBF in one district	4 m€ annually, of which 800.000€ MoFA (MFS)
HealthNet TPO	Psychosocial and mental health care to victims of war and the most vulnerable in society Health systems strengthening	- Direct intervention programs, training of staff and community workers - Special programmes for children, Congolese refugees, victims of torture and sexual violence, former child soldiers, orphans and vulnerable children - Sanitary provincial support programme, incl. remuneration system, management structures, and implementation support	App. 1.8 m€ in 2008; appr. 460.000€ TMF/MoFA In 2009-2010, 1.47 m€ MFS-Burundi

Annex 3: DR CONGO[14]

Organization	Goals/projects	Scope/activities	Financing
AZG-NL (jointly with MSF Belgium, France, Spain and Switzerland) 224 field staff and 2163 local staff (12/2007)	Direct medical aid delivery in crisis areas where the population is most vulnerable, particularly in the East (North-Kivu, South-Kivu, Katanga)	- Running, supporting and staffing hospitals and health posts and provision of direct medical aid - Basic primary and secondary care - Surgery - Treatment of diseases - (malaria, TB and HIV/AIDS) - Vaccination of children - Pregnancy and delivery care - Care for victims of sexual violence - Psychosocial care to victims of conflict - Care for malnutrition - Emergency planning and medical supplies for situations of conflict and epidemics	39,9 m€ in 2007, no funding from Dutch government sources
Cordaid	Disease-management programs Health systems strengthening	- Managing the execution of a large-scale national HIV/AIDS programme - Coordinating a malaria reduction programme in 4 health zones - Supporting and coordinating 4 large PBF programmes in South Kivu (2), Lulua, and Kasai - Health management training for 158 cadres and 27 health zones in 4 districts (incl. PBF)	7 m€ annually, of which some 1.8 m€ of MoFA (1.1 m€ basic healthcare and 0.7 m€ HIV/AIDS)
HealthNet TPO	Health systems strengthening Mental health programme	- Training and supervision of management teams and health workers in one zone in Northern Kivu (emphasis on disease control and reproductive health) - Support to victims of rape in the North-East: training and education to doctors and health workers and information campaign	Appr. 500.000€ TMF/MoFA in 2008 In 2009-2010, 1.33 m€ MFS-DRC

[14] The NL Red Cross does not implement projects in DRC but has provided 25 m€ in 2006 (revenues 3FM action) to the ICRC-programme in DRC for reunion of children with their family and for supplying medicines and medical materials

Annex 4: SUDAN

Organization	Goals/projects	Scope/activities	Financing
AZG-NL[15] (jointly with MSF Belgium, France, Spain and Switzerland) In 12/2007, there were 240 field staff and 2934 local staff (incl. Darfur 231/1997 staff)	Direct medical aid delivery in crisis areas where the population is most vulnerable in North and South Sudan, with a very large mission in Darfur	- Running, supporting and staffing hospitals, (mobile) health posts and provision of direct medical aid - Basic primary and secondary care delivery, incl. surgery - Mother and child health - Malnutrition care - Treatment for victims of violence - Mobile teams in remote areas - Treatment for TB, HIV/AIDS, Leishmaniasis - Psychosocial care, though in Darfur restricted to 'minor' psychiatric complaints on the order of the Sudanese government per 01/2009 - Emergency planning and medical supplies for conflict and epidemics	40,9 m€ in 2007, no funding from Dutch government sources
Cordaid (through various local partners)	Basic health services provision to local population and vulnerable groups	- Emergency PHC in South Darfur for IDPs, nomads and local population - PHC North and West Aweil to returnees and local population - Dioces Health Program for local population - Community-based healthcare programme to IDPs and returnees	3 m€ annually, of which appr. 50% Dutch funds through MFS (470.000€) and Basic Services Fund for NGOs
HealthNet TPO **(South-Sudan)**	Health system strengthening Psychosocial care programme	- PHC reconstruction in Wau district, incl. community and management structures - Targeting communities, IDPs and refugees	Appr. 350.000€ TMF/BuZa in 2008, In 2009-2010, 1.76 m€ MFS-Sudan
Red Cross-NL (through Sudanese Red Crescent and "As Well")	Basic health care for displaced persons in South Sudan (Juba) in 4 clinics Care for displaced and wounded in 7 camps in Kassala (north) Support to health clinics of 2 camps in Darfur	- humanitarian assistance - health infrastructure - staffing & supplies - HIV/AIDS programmes - curative care - mother and child care - consultation to children <5 - vaccinations - health education (cholera) - water & sanitation	2 m€ annually, partly funded by MoFA through TMF and now MFS

[15] Since early March 2009 AZG-NL is summoned to leave Sudan on the order of the Sudanes authorities