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A Call for a Systems- and Resilience-building Approach in UK Aid for Global Health Programming in Fragile and Conflict-Affected Settings

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Abstract

The briefing summaries the existing commitments and strategies on health systems strengthening (HSS) of the UK Foreign, Commonwealth and Development Office (FCDO) in fragile and conflict-affected settings (FCAS), sets out the rationale for and challenges of HSS in FCAS, together with evidence of what works and key recommendations for the FCDO in the delivery of its existing commitments. It draws together research evidence and practitioner insights from across 9 UK-based civil society organisations (CSOs) .

The briefing makes a series of recommendations based on the available evidence, including that priority is given to building resilient, adaptive, gender-sensitive health systems in FCAS. This an approach would benefit from longer-term funding cycles, with a focus on providing essential health service packages, with strong coordination between governmental authorities (where they exist), donors, healthcare providers and users, to ensure universal health coverage (UHC), health surveillance and monitoring.

Background

Fragile and conflict-affected settings or states (FCAS) are defined as countries with high levels of institutional and social fragility and/or those affected by violent conflict.[1] They are contexts within which there are multiple complex risks, resulting from a specific set of underlying causes combined with insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks.[2]

While definitions and lists of 'fragile context' vary according to who defines them and its purpose, the UK government had in the past defined the list based on data on state stability from the United Nations and the World Bank. The World Bank renews its list every year based on indicators that measure the quality of policy and institutions, and manifestations of fragility and a threshold number of conflict-related deaths relative to the population.

It is projected that 60% of the world's extreme poor will be living in FCAS by 2030.[3] The prevalence and scale of conflict (both long term and protracted crises and new conflicts such as the war in Ukraine, which is exacerbating commodity shortages and price inflation), combined with the COVID-19 pandemic and the climate crisis, are creating an overwhelming challenge.

The 2022 *UK Government's Strategy for International Development* states the UK's commitment to supporting the most vulnerable populations in FCAS to survive and thrive.[4] This briefing stresses the importance of taking a long-term and resilience-building approach in the UK's official development assistance (ODA) for global health in FCAS. This approach is undoubtedly difficult to implement, especially in unpredictable and volatile environments, clear solutions, but strategies for addressing the challenges are available.

This briefing is the work of a number of UK-based civil society organisations (CSOs) in the global health space (policy, research and implementing organisations – please see appendix for a complete list of contributors). Together, these organisations recognise the complexity and difficulty of health systems strengthening (HSS) in FCAS, but also the importance and potential if done well and with the correct investments prioritised.

This briefing summarises relevant Foreign, Commonwealth and Development Office (FCDO) commitments, sets out the need and rationale for health systems strengthening in FCAS, the challenges faced, examples of what works, and provides evidence-based recommendations.

1 World Bank, 'Classification of Fragile and Conflict-Affected Situations' (updated 2022) https://www.worldbank.org/en/topic/fragilityconflictviolence/brief/harmonized-list-of-fragile-situations
2 UNICEF, *Integrating Humanitarian Response and Development: Programme Framework for Fragile Contexts – Enhancing Programme and Operational Support in Fragile Contexts* (2018) https://www.unicef.org/media/96586/file/programmememe-Framework-Fragile-Contexts.pdf While definitions and lists of 'fragile context' vary according to who defines them and its purpose, the UK government had in the past defined the list based on data on state stability from the United Nations and the World Bank. The World Bank renews its list every year based on indicators that measure the quality of policy and institutions, and manifestations of fragility and a threshold number of conflict-related deaths relative to the population.
3 OECD, *States of Fragility 2020* (2020) https://doi.org/10.1787/ba7c22e7-en
4 FCDO, *UK Government's Strategy for International Development* (2022) https://www.gov.uk/government/publications/uk-governments-strategy-for-international-development

1

Summary of FCDO's existing commitments and strategies on HSS in FCAS

1 Summary of FCDO's existing commitments and strategies on HSS in FCAS

In May 2022, the UK government published its *Strategy for International Development*.[5] This strategy identifies global health as one of the UK's priority development areas, with health systems strengthening positioned 'at the core of our long-term approach'.[6] The strategy also prioritises life-saving humanitarian assistance and the UK as a global leader in driving more effective international responses to humanitarian crises. However, the two are not explicitly connected. There is no reference to the challenges of systems strengthening approaches when responding to emergencies and humanitarian interventions and the need to work in a coordinated and effective way across the humanitarian–development–peacebuilding nexus[7]. Similarly, while the strategy commits to a focus on women and girls – including a welcome commitment to reduce the gender gap and end gender-based violence – there is no mention of the importance of gender considerations in supporting equitable health systems.

Although the UK government does not have a global health strategy guiding its work (a gap that AfGH has highlighted over recent years), the FCDO published two health position papers in December 2021 – the *Ending Preventable Deaths of Mothers, Babies and Children by 2030: Approach Paper* (hereafter referred to as the *EPD Paper*) and the *Health Systems Strengthening for Global Health Security and Universal Health Coverage: FCDO Position Paper* (hereafter referred to as the *HSS Paper*).[8]

The *EPD Paper* highlights the maternal health inequities (including higher mortality rates) faced by people living in FCAS: they are some of the "most underserved and marginalised groups who are at higher risk of preventable deaths".[9] The FCDO commits to "work harder" in FCAS "to reach the women, adolescents, babies and children most affected" and notes the need to "increasingly cover[ing] humanitarian needs through longer-term health systems strengthening interventions, helping systems flex in response to displacements of populations and to prevent and treat severe acute malnutrition, whilst enhancing local capacity to anticipate and prepare for new shocks".[10]

The FCDO commits to championing the rights of people living in FCAS, greater disaggregation of data, "scale up in the use of minimum initial service package of Sexual Reproductive Health Rights (SRHR) interventions in acute crises" and "establishing durable, climate-resilient solutions in water-scarce fragile and conflict affected states".[11] The paper specifically identifies support for Gavi, the Vaccine Alliance, the Global Fund and the Global Financing Facility as important in delivering health services (including vaccines) to people living in FCAS. There are three "key actions" in the *EPD Paper* that relate to HSS in FCAS.[12] The first action notes the importance of "filling evidence gaps on SRHR in FCAS", the second action is strengthening the "resilience of services to prevent and treat wasting in fragile contexts" and finally to "catalyse action to accelerate the provision of climate-resilient WASH services".[13] The paper notes that these actions will need to be focused through country-level engagement and relate to improving efficiency.

5 *Ibid.*
6 *Ibid.*
7 The nexus approach stems in part from a recognition that emergency needs (and the identities of those most affected) are often symptoms of underlying issues that reflect broader inequalities and injustices. The nexus represents an opportunity to engage with these root causes and recognize that humanitarian crises can be caused and/or heightened by poor development policies and a lack of inclusive and appropriate development investment. Thus, meeting lifesaving needs at the same time as ensuring longer-term investment addressing the systemic causes of conflict and vulnerability has a better chance of reducing the impact of cyclical or recurrent shocks and stresses, and supporting the peace that is essential for development to be sustainable (see Reliefweb, 'The Humanitarian-Development-Peace Nexus: What does it mean for multi-mandated organizations?' (2019) https://reliefweb.int/report/world/humanitarian-development-peace-nexus-what-does-it-mean-multi-mandated-organizations)
8 FCDO, *Ending Preventable Deaths of Mothers, Babies and Children by 2030* (2021) https://www.gov.uk/government/publications/ending-preventable-deaths-of-mothers-babies-and-children-by-2030
9 *Ibid.*
10 *Ibid.*
11 *Ibid.*
12 *Ibid.*
13 *Ibid.*

The *HSS Paper* focuses on similar themes and reflects the FCDO's geographical focus on FCAS. The paper expands on the importance of HSS in FCAS to increase access to essential services and to improve infrastructure and "institutional capability".[14] The paper notes that this approach is important to ensure that health systems are better "able to respond to shocks and an influx in need" and to improve preparedness for disease outbreaks.[15] The *HSS Paper* underpins the FCDO's approach to HSS in FCAS with "do no harm" principles.[16] These principles are understood as building contextual understanding "to minimise the risk of potential harms and maximise our positive impact", including safeguarding against sexual exploitation and abuse and sexual harassment, and should be embedded in the design and delivery of programmes and partnerships.[17]

Recognition of the HSS-humanitarian nexus is lacking in the *Strategy for International Development*. However, the *HSS paper* highlights the importance of ensuring that "humanitarian interventions complement and reinforce longer-term support for the health system", through "creating better links between humanitarian and development actors" and similarly complementary approaches to longer-term aid and shorter-term humanitarian financing.[18]

Beyond these health-specific position papers, the UK has recognised the health inequalities experienced by people living in FCAS in other commitments:

The 2021 *G7 Compact on Famine Prevention & Humanitarian Crises* highlights the importance of timely funding for health interventions and "resilience strengthening", but does not explicitly refer to the importance of HSS.[19]

More recently, the UK's *2022–2030 Disability Inclusion and Rights Strategy* recognises the disproportionate impact that "exposure to conflict, violence and insecurity" has on the mental health and psychosocial wellbeing of people with disabilities, as well as experiencing "less access to support services".[20] However, this recognition does not translate into concrete commitments in the strategy for improving HSS in FCAS for people with disabilities – although the strategy does incorporate a new thread of work on inclusive health. While not specifically focused on FCAS, there also is a FCDO statement on UHC & World Health Assembly stating,

"Our ambition for inclusive health for all is guided by our commitment to Universal Health Coverage (UHC) and our co-sponsoring of the World Health Organisation (WHO) Resolution on the Highest Attainable Standard of Health for People with disabilities. To achieve UHC and unlock transformational change in global health, people with disabilities must be included; thus, equity and disability inclusion are central to FCDO's broader health objectives."[21]

The upcoming (revised) Women and Girls Strategy will also serve as an opportunity to embed HSS approaches in the UK's focus on progress for women and girls in FCAS.

14 FCDO, *Health Systems Strengthening for Global Health Security and Universal Health Coverage* (2021) https://www.gov.uk/government/publications/health-systems-strengthening-for-global-health-security-and-universal-health-coverage
15 *Ibid*.
16 *Ibid*.
17 *Ibid*.
18 *Ibid*.
19 FCDO, *G7 Famine Prevention and Humanitarian Crises Compact* (2021) https://www.gov.uk/government/publications/g7-foreign-and-development-ministers-meeting-may-2021-communique/g7-famine-prevention-and-humanitarian-crises-compact
20 FCDO, *FCDO Disability Inclusion and Rights Strategy 2022 to 2030* (2022) https://www.gov.uk/government/publications/fcdo-disability-inclusion-and-rights-strategy-2022-to-2030
21 FCDO, 'FCDO disability inclusion and rights strategy 2022 to 2030: building an inclusive future for all: a sustainable rights-based approach' (updated 2022) https://www.gov.uk/government/publications/fcdo-disability-inclusion-and-rights-strategy-2022-to-2030/fcdo-disability-inclusion-and-rights-strategy-2022-to-2030-building-an-inclusive-future-for-all-a-sustainable-rights-based-approach

2

Need and rationale for HSS work in FCAS

2 Need and rationale for HSS work in FCAS

Scale of health needs in FCAS

Approximately 1.8 billion people currently live in FCAS. This is 23% of the world's population and represents over 75% of the total number of people living in extreme poverty. By 2030, this number is expected to increase to more than 2.2 billion, driven by growing violence, inequality and persisting acute and chronic conflicts, resulting in population displacement and systems breakdown.[22]

Today, refugee and displaced populations are at record levels,[23] the COVID-19 pandemic pushed and drove an additional 97 million people into extreme poverty in 2020,[24] and the effect of climate change is driving marginalised people even further behind.[25]

Fragility and conflict pose major threats to the achievement of the Sustainable Development Goals (SDGs). None of the states classed as fragile contexts are on track to meet the SDGs on hunger, health, gender equality and women's empowerment. Some of the most disadvantaged people are the worst affected by fragility, conflict and shocks, and this represents one of the greatest challenges to "leave no-one behind" in achieving UHC.

Health system functionality in FCAS

Maternal, under-five and neonatal mortality are commonly used markers of health system functionality, and the under-five mortality rate in the 58 countries categorised as 'fragile' based on the World Bank definition was (on average) almost three times higher than in all other countries in 2019, and even higher in extreme fragile contexts. In 2018, the under-five mortality rate in fragile contexts was almost twice the global average, and the maternal mortality rate is four times higher than in non-fragile contexts.[26]

Performance in health access and quality is better than the global average in only 6 of the 57 fragile contexts in the 2020 OECD fragility framework.[27] Resilience measured on indicators of health pointed to fundamentally weak – and in some cases, critically weak – health systems in fragile contexts.

The COVID-19 pandemic has both highlighted and exacerbated health disparities. In contexts such as FCAS, where the health system is already strained, preventative services (such as antenatal care or SRHR) may not be deemed a priority. This may deepen gaps in services and create more vulnerability, making the goal of achieving SDG3 more difficult.[28]

22 OECD, *States of Fragility 2020* (2020) https://doi.org/10.1787/ba7c22e7-en
23 UNHCR, 'Figures at a glance' (updated 2022) https://www.unhcr.org/uk/figures-at-a-glance.html
24 World Bank blogs, 'Updated estimates of the impact of COVID-19 on global poverty: Turning the corner on the pandemic in 2021?' (2021) https://blogs.worldbank.org/opendata/updated-estimates-impact-covid-19-global-poverty-turning-corner-pandemic-2021
25 OECD, *States of Fragility 2020* (2020) https://doi.org/10.1787/ba7c22e7-en
26 J. Marley and H. Desai (2020), *Fragility and Agenda 2030: Navigating Shocks and Pressures in Fragile Contexts* (2020) https://doi.org/10.1787/65d5cb9c-en
27 OECD, *States of Fragility 2020* (2020) https://doi.org/10.1787/ba7c22e7-en
28 M.D. Landry et al., 'Health system strengthening in fragile and conflict-affected states: a call to action' (2021) BMC Health Serv Res 21: 726 https://doi.org/10.1186/s12913-021-06753-1

HSS within FCAS – the need for a resilient system

In order to address the critical health challenges within FCAS, it is necessary to help build health systems that are resilient to shocks and stressors – i.e. they are able to absorb, adapt and transform in the face of conflict and violence, epidemics and health threats, natural disaster and population movements – and deliver responsive, effective, quality, inclusive and gender-equitable services that leave no one behind. In these contexts, improving health service delivery not only stands to make significant gains in overall population health indicators, but also has the potential to contribute to reducing state fragility,[29] and hence global fragility.

In Afghanistan, 40% of the population lack access to essential health services. The impacts of recent radical political change have led to further deteriorations in essential healthcare provision, as members of the health workforce have fled the country, sanctions have been imposed and government capacity is limited. Health systems are struggling to meet the demand for its services at a time when demand is growing. Currently, 27 out of 34 provinces are classified as food-insecure, leading to Global Acute Malnutrition (GAM)[30] now exceeding 20%, with approximately 1 million children at risk of dying.

Asuntha Charles, CEO of World Vision Afghanistan, highlights the need for building a resilient health system:

"Short-term funding with a focus on emergency-response will not be sufficient. It is crucial that we invest in building resilience of... the health and food systems... Strengthening community-based health systems should now be the new approach."

In FCAS, HSS is about more than providing short-term funding and emergency response for the health impacts of acute-onset crises. It is about building health systems that take account of the humanitarian–development–peacebuilding nexus (HDPN). Taking from HDPN thinking, this will involve understanding and tracking context indicators and health indicators, then scenario planning based on how these indicators might change, using indicator data to rapidly dial up and down the different elements of health programming, to anticipate early and to respond to changing health and nutritional needs. Organisations such as World Vision have been piloting such approaches to multi-sector work across the nexus, with encouraging early results.[31]

Save the Children has also examined the interaction between some of its humanitarian health and nutrition project efforts and changes in critical health systems functions. A study of its work concluded that shared metrics for systems and performance outcomes, with stronger process and focused outcome metrics at project level, can maximise learning from local/subnational efforts and support systems strengthening. Humanitarian implementation agencies and donors can increase their contribution to national systems and to global learning, while maintaining the focus on addressing peoples' needs as the ultimate driver of systems change.[32]

Research also suggests that challenges of multiple (and rapidly changing) actors and resource flows, potentially conflicting humanitarian (emergency) and development approaches, weak state actors and systems can be addressed by identifying commonalities in the principles behind humanitarian and development efforts, and supporting implementing organisations in efforts to better link relief, rehabilitation and development.[33] How to work effectively across the nexus is an evolving area and one that requires further research and learning.

29 A. ter Veen and S. Commins, *From Services to Systems: Entry Points for Donors and Non-state Partners Seeking to Strengthen Health Systems in Fragile States* (2011, commissioned by World Vision Canada) https://luskin.ucla.edu/sites/default/files/download-pdfs/ter%20Veen%20Commins%20World%20Vision%20HSS%20in%20FS%202011.pdf

30 OCHA, *Afghanistan Humanitarian Needs Overview 2022* (2022) https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2022-january-2022. Global acute malnutrition (GAM) is a measure of acute malnutrition in refugee children aged between 6 and 59 months. GAM provides information on the percentage of all children in this age range in a refugee population who are classified with low weight-for-height and/or oedema. GAM is also often referred to as wasting. (See UNHCR, 'Acute malnutrition threshold' (undated) https://emergency.unhcr.org/entry/32604/acute-malnutrition-threshold.)

31 World Vision, 'FCPA: Fragile Contexts Programming Approach: Designing for impact in fragile contexts' (2022) https://www.wvi.org/publications/brochure/peacebuilding-conflict-sensitivity/fcpa-fragile-contexts-programming-approach

32 USAid and CoreGroup, Brief: Strengthening Health Systems in the Humanitarian-Development Nexus Experience and Lessons Learned from Pakistan and Sudan (2019 https://coregroup.org/wp-content/uploads/2020/01/Save-the-Children-HSS-Brief-Sudan-Pakistan_FINAL.pdf

33 *Ibid*.

3

Main challenges of HSS work in FCAS

3 Main challenges of HSS work in FCAS

Strengthening health systems in FCAS, where the context is "insecure and chaotic, health governance is weak, information scant, institutions fragile, financing inadequate and unpredictable, healthcare provision fragmented and volatile" is a challenge.[34] All these factors contribute to an "obscuring of the understanding of the most critical health system issues".[35] A recent K4D resource toolkit on HSS summarises wider challenges to HSS in FCAS typically including "deficits in legitimacy, insecurity and capacity, destruction of health infrastructure and supply systems, lack of health workers, fragmentation and lack of coordination between multiple formal and informal providers, weak governance capacity to coordinate and develop the health system anew, and lack of capacity to provide essential services to the population."[36]

The most critical health systems challenges in FCAS, set out below, have been identified by practitioners within the organisations contributing to this paper. They are set out here in accordance with the WHO health systems framework.

Service delivery

There are three core areas of service-delivery challenge. First, within FCAS there are often multiple and fragmented service delivery models across multiple providers, including government providers, private providers, INGO providers and community healthcare. While they should all be accountable downward to healthcare service users, they each have different sources of funding, which results in different upward accountabilities.

This, together with multiple competing and changing health priorities within FCAS, can make it harder to align and co-ordinate priorities in dynamically changing contexts and to take account of existing national priorities and referral pathways, and can result in parallel systems for service delivery. These factors can contribute to the challenge of providing a comprehensive package of services to a population, while also maintaining monitoring and prevention activities such as disease surveillance and infection prevention.

Secondly, people on the move are a key characteristic of FCAS. Providing consistent healthcare along displacement routes in the country as well as cross-border routes can be challenging, as can providing healthcare in hard-to-reach or more dangerous areas. According to a recent survey conducted on status of refugees and displaced population by World Vision in 11 FCAS, one in every four people surveyed reported having lost a family member within the last year, with four out of 10 of those deaths being due to COVID-19. 82% were unable to meet their basic needs, reporting struggling to afford things like healthcare, and 78% of all refugees and IDPs interviewed by were not able to meet their daily nutrition needs.[37] Dilara, a Rohingya refugee in Cox's Bazar, Bangladesh, said:

"The children couldn't step out of [our] home, their father couldn't earn a living, and we had to bother him for food. As a mother, I was scared if my children went out. I was worried if my kids would get infected by others . . . [My] kids also suffered for the food. I passed a hard time feeding my babies." [38]

Thirdly, social stigma and discrimination, particularly in relation to gender-based sexual violence, can result in low levels of reporting and referral, preventing those in need to access needed healthcare.

34 UHC2030 Technical Working Group in Fragile Settings, *No.1 – Guidance Document to Assess a Healthcare Arena Under Stress* (2019) https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/UHC2030_Working_Groups/2017_Fragility_working_groups_docs/UHC2030_Guidance_on_assessing_a_healthcare_arena_under_stress_final_June_2019.pdf
35 *Ibid.*
36 B. Scott et al., *What Works for Health Systems Strengthening: An Overview of the Evidence – Resource Toolkit* (2022) https://k4d.ids.ac.uk/resource/what-works-for-health-systems-strengthening-an-overview-of-the-evidence-resource-toolkit/
37 World Vision, *Hungry and Unprotected Children: The Forgotten Refugees* (2022) https://www.wvi.org/sites/default/files/2022-06/WRD_report_2022%20final%20reduced.pdf
38 *Ibid.*

Health workforce

Healthcare provision in FCAS is often characterised by a shortage of skilled health staff, which leads not only to challenges in the provision of quality health service but competition by healthcare providers for these staff, resulting in unequal staff pay across different service providers. State healthcare provision can be undermined by this disparity in pay, and this can also be compounded when government health workers across all cadres are not paid or experience long periods without remuneration. The lack of skilled health staff also makes it difficult to provide an even distribution of health workers across geographic areas, particularly in higher-risk and harder-to-reach locations.

Staff retention and motivation is more challenging in a context in which health workers can be targets of violence in conflict situation, and where opportunities for training and mentorship are lacking due to funding constraints. Since the outbreak of conflict in Syria, the number of health workers in practice and in training has dropped dramatically. According to a recent *Conflict & Health* article, there have been several deaths among healthcare workers and significant numbers have been forced to flee the country.[39] The same article reports that, according to the World Bank, in 2018 the number of doctors per 1,000 population had decreased to 0.3, from the figure of 1.5 in 2010, compared with the average in Europe in 2017 of 4.9 doctors per 1,000 population. In Myanmar, in the 12 months that followed the country's coup, at least 492 attacks and threats against health workers and health infrastructure were perpetrated.[40]

Health information systems

Challenges start with data collection, which can often be limiting and not prioritised in fluid and rapidly changing contexts. There is also the risk that data will be politically influenced. Secondly, a lack of digital infrastructure and vertical harmonisation across health information systems makes access to data challenging, particularly as health data is often collected by a range of healthcare providers. Furthermore, if data is not analysed and interpreted, then it can undermine decision-making, adaptation of services to changing needs and prioritisation of services.

Access to essential medicines

At an operational level, the lack of good health data and constantly changing needs make it difficult to anticipate what medicines will be needed in what volumes to serve critical health needs. In addition, the lead-in times for getting medicines from suppliers to those that need them is often too slow. Implementing partners are faced with a lack of enforcement of drug procurement policies by the government, which leads to a lack of adherence by international partners, which in turn creates inefficiencies in the drug supply system overall. Pharmaceutical procurement lead-in time can be long, the process of getting pharmaceutics through customs and imported into a country can be protracted, and the process of storing and transporting them to where they are needed (which can mean crossing areas controlled by different armed groups or authorities) can also be slow. Once medicines do arrive, the capacity to administer them can be limited, due to the lack of qualified and trained health professional required to safely administer them. All of these factors can contribute to the fundamental shortage of essential medicines.
At a regulatory level, there can be risks of poor regulation of medicines, leading to poor quality or inappropriate use.

39 Y. Bdaiwi et al., 'Challenges of providing healthcare worker education and training in protracted conflict: a focus on non-government controlled areas in north west Syria' (2020) *Conflict & Health* 14:42 https://doi.org/10.1186/s13031-020-00287-9
40 Insecurity Insight, 'Violence against or obstruction of health care in Myanmar: May 2022 update' (2022) https://insecurityinsight.org/wp-content/uploads/2022/05/Violence-Against-Health-Care-in-Myanmar-May-2022-update.pdf

Financing

Those requiring healthcare can often not afford to pay for it. Countries experiencing FCAS are often ones where there is a low level of economic development and, in conflict situations, governmental spending priorities may often be focused elsewhere. Aid funding can tend to focus on acute emergency needs, or short-term cycles of funding where vertical health programming is often financed in silos. Different donors have different priorities and funding can be needs-based but also seek to serve a political aim – although institutional donors do attempt to work together to co-ordinate their funding, to reduce duplication and gaps. Overall, there is a lack of funding for fostering resilient and adaptable health systems, and funding mechanisms themselves often constrain the use of adaptive programming that is required to adapt to challenging FCAS.

Leadership/Governance

Governments usually set the health strategic and policy priorities of the country, and all others (from institutional donors to healthcare providers) should align with this. However, in FCAS there is not always a willing or able government, so in some FCAS situations the humanitarian cluster system seeks to prioritise needs and coordinate those seeking to meet them – but this, too, is not always present. Added to this, those providing the funding for healthcare in FCAS may have differing policy and political objectives, and different conditionalities, procurement and compliance rules.

A Ministry of Health and Sanitation official from Sierra Leone said,

"These meetings (with donors) were completely dominated by two donors having their ideological fight effectively. We achieved very little...Interestingly, people tell you it's the government to decide...So I did an appraisal and did a comprehensive thing and went to present. As I presented, I remember a furious lady who got up and said 'No, no, no – we will not accept that! It's not the one.' I said, 'You said the government is to decide.' Well, she got up in the meeting and said 'No, no.'"[41]

This all adds to the complexity and challenge of establishing a strategic, coordinated approach to healthcare provision in FCAS to fund the building of resilient and adaptive health systems.

41 ReBUILD Consortium, 'Policy and power' (2016) https://www.youtube.com/watch?v=h4NnfBJtLho&list=PLzuoUvbPT3tTWg11eD4BSZoAZJEnK_BML&index=4&t=129s

4

Evidence on what works to foster HSS work in FCAS

4 Evidence on what works to foster HSS work in FCAS

General factors that enable HSS

A systematic literature review commissioned by FCDO on effective HSS approaches in different contexts[40] has highlighted the following key factors, which if present are likely to increase HSS success: political commitment to a process, early engagement with national authorities, shared societal values, taking advantage of windows of opportunity, sustained commitment, quality of implementation, and iterative learning and adaptation.[42]

The review also highlighted key intervention areas where evidence shows that positive outcomes have been achieved: supporting civil participation, leveraging collaborative models involving different stakeholders working to a common objective, bundled retention packages for health staff in underserved areas, and most health-financing interventions. Community engagement in the design and implementation of interventions, along with capacity development and mentoring of clinical and managerial staff, have also been found to promote greater effectiveness of interventions.

Evidence on HSS in FCAS is more mixed, with a more complex, changing, and multiple actor environment with often weak government.[43]

Key elements in HSS in FCAS

Service delivery

Intervention packages should be based on assessments of the country's needs, existing resources and available funding, aiming to "rapidly scale-up health services with proven, affordable and contextualised health interventions and replace the fragmented, uncoordinated, vertically-dominant services characteristic in many post-conflict settings".[44]

Essential healthcare packages are commonly developed in FCAS in order to focus support on key service areas, and some studies have reviewed their development, costing and financing. Given higher levels of resource scarcity in many FCAS settings, coupled with high need, there is an even greater need to focus resources on priority services targeted at vulnerable populations.

The development of essential service packages can form the basis for pooled funding by government and donors. However, providers need to be adequately trained, resourced and incentivised to implement chosen services. Those packages can then provide a basis for expansion of coverage to populations at risk, including a progressive shift from a focus on supporting health facilities to a population-based approach through District Health Management supported by community engagement.[45]

42 S. Witter et al., *Evidence Review of What Works for Health Systems Strengthening, Where and When? Report prepared by the ReBUILD and ReSYST Research Consortia for FCDO* (updated 2021) https://www.rebuildconsortium.com/wp-content/uploads/2019/08/HSS-revision-03-03-21.pdf

43 T. Martineau et al., 'Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states' (2017) *BMJ Global Health* 2(2): e000327 http://dx.doi.org/10.1136/bmjgh-2017-000327 and S. Fustukian, 'Critical factors in rebuilding health systems after crisis' (undated, Key Issue Guide – HSG Thematic Working Group on Health Systems in FCAS) https://www.eldis.org/keyissues/critical-factors-rebuilding-health-systems-after-crises

44 S. Fustukian, 'Critical factors in rebuilding health systems after crises: What are the key building blocks when it comes to rebuilding health systems in fragile and conflict-affected states?' https://www.eldis.org/keyissues/critical-factors-rebuilding-health-systems-after-crises and see also A.M. Sibai, 'Lessons learned in the provision NCD primary care to Syrian refugee and host communities in Lebanon: the need to "act locally and think globally"' (2020) *J Public Health* 42(3): e361–8 https://doi.org/10.1093/pubmed/fdz096

45 WHO, *Synthesis of Evidence and Policy Recommendations: Health Financing Policy and Implementation in Fragile and Conflict-affected Settings* (2020) https://www.who.int/publications/i/item/health-financing-policy-and-implementation-in-fragile-and-conflict-affected-settings

Enabling local managers to adapt service delivery as needed can be helpful in relation to shocks – for example, mobile sites deployed in Syria, which the devolved management permitted and supported.[46] Demand-driven and community-driven interventions showed effectiveness in improving child health in Angola, a conflict-affected country.[47] It is also important, when seeking to increase health service utility rates, to consider barriers faced by service users. For example, evidence shows violent conflict and perceptions of insecurity can deter users' utilisation of healthcare services.[48]

Quality of care is important in all contexts. To improve quality of care in FCAS, guidance from World Health Organization (WHO) recommends working with local actors to develop a shared understanding of high-priority health-care quality issues, agreeing a small number of quality goals aligned with these priorities and quality challenges, selecting a pragmatic set of quality interventions, and developing an operational plan to support implementation.[49]

Health workforce

Health-worker recruitment, distribution, retention and performance are arguably the most critical factors affecting the performance of a health system.[50] In FCAS, where health systems and health worker livelihoods have been disrupted, it is particularly important that the health system can respond appropriately to the needs both of health workers and of the communities they serve during conflict/crisis and during rebuilding of resilient health systems. Policies and strategies addressing recruitment, remuneration and retention are therefore an essential first step.[51]

Staff and managers in fragile settings can show remarkable resilience, working in dangerous conditions and keeping services functioning through local adaptations. National and international support should focus on reinforcing and rewarding resilience and providing decision spaces and flexibility for good staff to thrive and drive forward better healthcare services for all, along with appropriate policies related to deployment and incentives that ensure a fair balance across sectors and geographical distribution.

Balanced incentive packages, which focus on more than short-term financial measures, are key to retaining staff in hard-to-serve areas. These should include recognition of their role and achievements in challenging circumstances, practical measures to improve security, the provision of decent housing, working conditions, training and pay, and the re-establishment of trust, communication, and teamwork.[52]

Remuneration policies also need to take into account the role of multiple actors and the different facets of pay that matter to health staff (i.e. not just the level of remuneration itself, but ease of access, reliability, transparency etc.).

The role of frontline or close-to-community providers is often overlooked despite the essential role they play in extending services in remote areas. Community health workers (CHWs) are key and trusted health providers in emergency and conflict settings, because of their local knowledge and embeddedness in communities. They are critically important in continuing to provide essential healthcare when the health system is under pressure, and particularly well placed to inform communities about emerging health threats, including pandemics and new disease outbreaks.[53]

46 Z. Jamal et al., 'Health system resilience in the face of crisis: analysing the challenges, strategies and capacities for UNRWA in Syria' (2019) *Health Policy and Planning* 35(1): 26–35 https://doi.org/10.1093/heapol/czz129
47 E.W. Djimeu, 'The impact of social action funds on child health in a conflict affected country: evidence from Angola' (2014) *Social Science & Medicine* 106: 35–42 https://doi.org/10.1016/j.socscimed.2013.12.027
48 M. Badiuzzaman et al., 'Improving maternal health care in a post conflict setting: evidence from Chittagong Hill Tracts of Bangladesh' (2020) *The Journal of Development Studies* 56(2): 384–400 https://doi.org/10.1080/00220388.2018.1554211
49 WHO, *Quality of Care in Fragile, Conflict-affected and Vulnerable Settings: Taking Action* (2020) https://www.who.int/publications/i/item/9789240015203
50 ReBUILD Consortium, *Establishing a Responsive and Equitable Health Workforce Post Conflict and Post Crisis* (undated) https://rebuildconsortium.com/media/1486/health-workers-brief-2016.pdf
51 T. Martineau et al., 'Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states' (2017) *BMJ Global Health* 2(2): e000327 http://dx.doi.org/10.1136/bmjgh-2017-000327
52 S. Witter, 'How do health workers experience and cope with shocks? Learning from four fragile and conflict-affected health systems in in Uganda, Sierra Leone, Zimbabwe and Cambodia' (2017) *Health Policy and Planning* (2017) 32 (suppl 3): iii3–iii13 https://doi.org/10.1093/heapol/czx112
53 N.P. Miller et al., 'Community health workers in humanitarian settings: scoping review' (2020) *J Glob Health* 10(2):020602 https://doi.org/10.7189/jogh.10.020602

However, CHWs face many challenges in FCAS, including safety and access to specific communities, along with several gender-related challenges. They need appropriate remuneration as well as training, supervision, and community support. Integration of CHWs in national health systems, and involving them in emergency preparedness as well as in recovery, can support resilient systems.[54]

Health financing

Clearer evidence is emerging around health financing in FCAS, with the WHO and the ReBUILD Consortium producing specific guidance,[55] recognising that safeguarding the financing of critical health system functions in FCAS is a priority, given the increased risks to population health security.

Health-financing policy in FCAS should be guided by a set of principles to avoid the development of schemes or sub-systems inconsistent with UHC. Multiple, uncoordinated actors, often external,, can lead to the development of interventions that are unsustainable due to high cost or complexity, and that neglect to invest in the foundational elements essential for a resilient health system. In contrast, coordinated actions that use and support domestic systems where possible, or otherwise mirror critical public functions, can strengthen health-system resilience. Examples of coordinated action include pooling of funds, using a common pay scale for health workers' salaries, and ensuring that funding for critical inputs required for service delivery takes priority.

Cash and voucher assistance can play a critical role in protecting human welfare in FCAS by supporting vulnerable households to meet both health and non-health needs. However, given the agreed interagency policy to suspend user fees for essential healthcare services in complex emergency settings, unconditional or unrestricted cash transfers should not inadvertently contribute to a fee-charging culture for priority services, which would undermine progress towards UHC.

Health information systems

Use of mHealth technology is also applicable in FCAS.[56] Community-based or event-based disease surveillance is effective in detecting outbreaks,[57] but this may not add much value in a dense refugee-camp setting if facility-based surveillance is already in operation.[58]

Access to essential medicines

Evidence on what works to address the challenges set out in section 3 in relation to access to essential medicine is limited. A recent review of health interventions in humanitarian crises found no articles explicitly focused on interventions related to access to medicines.[59]

One study from Afghanistan observed that implementing a "basic package of health services" approach did increase the supply of essential medicines.[60] In Myanmar, a model in one region, which integrated both ethnic and national health system approaches, was observed to have helped channel essential medicines and health human resources to ethnic regions.[61]

54 W. Mansour and J. Raven, *The Gendered Experience of Close-to-community Providers in Fragile and Shock-prone Settings: Implications for Policy and Practice During and Post COVID-19 – Global Document Review (*ReBUILD Consortium, 2021) https://www.rebuildconsortium.com/wp-content/uploads/2022/01/CTC-study-global-review-report-FINAL.pdf
55 WHO, *Synthesis of Evidence and Policy Recommendations: Health Financing Policy and Implementation in Fragile and Conflict-affected Settings* (2020) https://www.who.int/publications/i/item/health-financing-policy-and-implementation-in-fragile-and-conflict-affected-settings
56 K. Jia and K. Mohamed, 'Evaluating the use of cell phone messaging for community Ebola syndromic surveillance in high risked settings in Southern Sierra Leone' (2015) *African Health Sciences* 15(3): 797–802 https://doi.org/10.4314/ahs.v15i3.13
57 C.Mbaeyi et al., 'Strengthening acute flaccid paralysis surveillance through the village polio volunteers program in Somalia' (2018) *Clin Infect Dis* 67(6): 94–6 https://doi.org/10.1093/cid/ciy180, Z.J. Li et al., 'A practical community-based response strategy to interrupt Ebola transmission in Sierra Leone 2014–2015 (2016) Infect Dis Poverty 5: 74 https://doi.org/10.1186/s40249-016-0167-0 and A. Metuge et al., 'Humanitarian led community-based surveillance: case study in Ekondo-titi, Cameroon' (2021) *Conflict & Health* 15: 17 https://doi.org/10.1186/s13031-021-00354-9
58 E. Van Boetzelaer et al., 'Evaluation of community based surveillance in the Rohingya refugee camps in Cox's Bazar, Bangladesh, 2019' (2020) *PLoS ONE* 15(12): e0244214 https://doi.org/10.1371/journal.pone.0244214
59 S. Doocy et al., An Evidence Review of Research on Health Interventions in Humanitarian Crises: 2021 Update (2022) https://www.elrha.org/researchdatabase/the-humanitarian-health-evidence-review-2021-update/
60 W. Newbrander et al., 'Afghanistan's basic package of health services: its development and effects on rebuilding the health system' (2014) *Global Public Health* 9 (suppl 1: S6-–S28 https://doi.org/10.1080/17441692.2014.916735
61 K. Tang and Y. Zhao, 'Health system strengthening in post-conflict ethnic regions of Northeastern Myanmar: a qualitative study' (2019) *Health Policy and Planning* 34(2): 151–9 https://doi.org/10.1093/heapol/czz016

But other approaches may be needed that address production and supply challenges. This could include support to increase or establish regional pharmaceutical manufacturing in more stable countries within regions where there are FCAS, while also ensuring a strong regulatory environment for generic drug production, to avoid an increase in counterfeit drugs[62] and to give donors assurance that any pharmaceuticals they are funding meet quality and safety standards.

Leadership/Governance

Post-conflict/crisis contexts are characterised by an influx of multiple players, so efforts to support stakeholder coordination and build strong, responsive national and local institutions are critical.[63] It is important to apply health development principles early in emergency settings to ensure longer-term perspectives and planning. Tracking the intentions of international actors at local level will help to predict gaps in service delivery and minimise potential threats to longer-term health outcomes.

Where there is no legitimate government in place, decentralised planning, analysis and funding approaches may be appropriate. A coordinating body of active stakeholders can function effectively if well-represented and democratically run.[64]

Interventions should consider how resource distribution may support or hinder linkages between governments, humanitarian, and development actors. It is important to be aware of the impact that power relations and vertical programmes may have on longer-term HSS. Involvement of local partners in needs assessments and decision-making will help strengthen capacity at national and sub-national levels. Supporting and building trust between actors – users, providers, government, and other agencies – is a critical issue in FCAS, where trust has frequently been significantly undermined.[65]

Qualitative studies[66] and systematic reviews[67] have highlighted the importance of strong health management systems, especially at the district level, for strengthening the health system. Good management can ensure better resource utilisation,[68] guarantee staff retention and speed up recruitment procedures, in addition to improving service delivery.

According to the recent K4D resource toolkit on HSS, guidance for working on HSS in FCAS often highlights the need for innovation in models of "best practice" (seeking pragmatic solutions even if these are not optimal), long-term support for institutional strengthening, politically sensitive engagement, greater focus on effective aid coordination (including between development and humanitarian actors), adaptability in the face of complexity and change, and ensuring that development partners do no harm.[69]

62 S. Basak, 'As Africa seeks greater pharma self-reliance, think generics' (2022, World Bank Blogs) https://blogs.worldbank.org/health/africa-seeks-greater-pharma-self-reliance-think-generics
63 T. Martineau et al., 'Leaving no one behind: lessons on rebuilding health systems in conflict- and crisis-affected states' (2017) *BMJ Global Health* 2(2): e000327 http://dx.doi.org/10.1136/bmjgh-2017-000327
64 A. Claxton et al., *Negotiating Health in a Fragile State: A Civil Society Perspective. A Case Study of the Global Fund TB Project in Somalia* (2010, Global Health Programme Working Paper N5 2020, The Graduate Institute, Geneva) https://www.graduateinstitute.ch/library/publications-institute/negotiating-health-fragile-state-civil-society-perspective-case
65 *Ibid*.
66 M. Lembani et al., ;Understanding key drivers of performance in the provision of maternal health services in eastern cape, South Africa: a systems analysis using group model building' (2018) *BMC Health Serv Res* 18: 912 https://doi.org/10.1186/s12913-018-3726-1; S. Malaku et al., 'Decentralization and health care prioritization process in Tanzania: from national rhetoric to local reality' (2011) *International Journal of Health Planning and Management* 26(2): e102–e120 https://doi.org/10.1002/hpm.1048, M. Tetui et al., 'A participatory action research approach to strengthening health managers' capacity at district level in Eastern Uganda' (2017) *Health Res Policy Syst* 15 https://doi.org/10.1186/s12961-017-0273-x and S. Cleary et al., 'Enabling relational leadership in primary healthcare settings: lessons from the DIALHS collaboration' (2018) *Health Policy and Planning* 33(suppl 2): ii65–ii74 https://doi.org/10.1093/heapol/czx135.
67 S. Witter et al., *Evidence Review of What Works for Health Systems Strengthening, Where and When? Report prepared by the ReBUILD and ReSYST Research Consortia for FCDO* (updated 2021) https://www.rebuildconsortium.com/wp-content/uploads/2019/08/HSS-revision-03-03-21.pdf
68 M. Tetui et al., 'A participatory action research approach to strengthening health managers' capacity at district level in Eastern Uganda' (2017) *Health Res Policy Syst* 15 https://doi.org/10.1186/s12961-017-0273-x
69 B. Scott et al., *What Works for Health Systems Strengthening: An Overview of the Evidence – Resource Toolkit* (2022) https://k4d.ids.ac.uk/resource/what-works-for-health-systems-strengthening-an-overview-of-the-evidence-resource-toolkit/

Gender equity in HSS in FCAS

Throughout the world, gender norms, roles and expectations restrict and undermine women's potential, behaviour and freedom. Women and girls often bear the brunt of the impact of conflict, and the turmoil and violence of war can exacerbate gender inequalities. In general, gender inequity undermines the ability of health systems to improve health outcomes for women and girls, non-binary people and also for men and boys.

Countries recovering from conflict and fragility often engage in wide-ranging institutional reforms to address inequities, including within the health system.[70] The post-crisis moment is often an opportunity to 'build back better'. Donor funds flow, social norms are in a state of flux, and there may be an appetite for political change. If approached mindfully, the health system is a set of institutions, processes and people that can shape society's perceptions of gender norms, roles and relations in positive ways.

Unfortunately, health system interventions have generally failed to reflect upon how gender norms are replicated by the health system, and how the health system can transform these gender norms and promote gender equity. And although current global health policy prioritises improving the health of women and girls, there is limited understanding on how health system interventions contribute to the broader goal of gender equity.

This can be addressed through the use of appropriate indicators (including data that is disaggregated by sex) and by understanding why the health needs of women and men differ, recognising that health is not only influenced by biology but also by the gender norms that undermine women and girls. Gender-equitable benchmarks across the different building blocks of the health system can help to track progress in improvements in health systems reform.[71] It can also be addressed through pro-gender-equity health workforce interventions. Guidance by RinGs (Research in Gender and Ethics) paints a picture of what a gender equitable health system looks like, along with further detailed suggestions for action to achieve this.[72]

70 V. Percival et al., 'Health systems and gender in post-conflict contexts: building back better?' (2014) *Conflict & Health* 8: 19 https://doi.org/10.1186/1752-1505-8-19
71 V. Percival et al., 'Are health systems interventions gender blind? examining health system reconstruction in conflict affected states' (2018) *Globalization and Health* 14: 90 https://doi.org/10.1186/s12992-018-0401-6
72 Research in Gender and Ethics (RINGS), *Adopting a Gender Lens in Health Systems Policy: A Guide for Policy Makers* (2020) https://www.ringsgenderresearch.org/wp-content/uploads/2020/01/Adopting-a-gender-lens-in-health-systems-policy.pdf

5

Recommendations

5 Recommendations

Below, is a collated list of key recommendations for the UK government, which will enable the government to fulfil and build on its existing commitments and strategies on HSS in FCAS.

1 In light of the UK's *Strategy for International Development*:

Ensure that humanitarian interventions are planned and implemented in a way that contributes to long-term health systems for vulnerable populations, while meeting immediate health needs. This means applying health development principles early in emergency settings, with longer-term perspectives and planning.

Support partner organisations and their workforces to better work within a humanitarian–development–peacebuilding nexus. This should consider how resource distribution may support or hinder linkages between governments, humanitarian and development actors, and involve local partners in needs assessments and decision-making to strengthen capacity at national and sub-national levels.

Prioritise funding for increased data collection, disaggregated by gender, age and disability, ensuring that this data is used for evidence-based decision-making in programmes and policies in FCAS and that there is analysis by FCAS/non-FCAS for core development indicators as well as inputs (i.e. FCDO funding). Women and persons with disabilities, among others, should be involved in meaningful participation of data collection or programming.

Allocate intentional funding for research and learning about what works and why in HSS in FCAS to build up useful, actionable evidence.

2 In light of the FCDO's *HSS Paper*

The FCDO should operationalise the *HSS Paper*, ensuring that its ambition and approach are embedded throughout the FCDO's health programmes in FCAS, in the UK's *Strategy for International Development* and the upcoming Global Health Strategic Framework, including as part of humanitarian health interventions.

Health workforce

Support balanced and harmonised pay and incentive packages for health workers across all areas of the country, focusing on more than short-term financial measures: providing appropriate supervision, training, housing, working conditions and mental health support, and working to re-establish trust, communication, and teamwork.

Recognise health workers' resilience in highly challenging circumstances, with practical measures to improve security, and providing support post-conflict/crisis with appropriate policies on deployment and incentives to ensure a fair balance across sectors and geographical distribution. There should be a focus on retention in hard-to-serve areas.

Support community health workers as critically important actors in health systems under pressure, including in their role to inform communities about emerging health threats.

Access to essential medicines

An "essential health service package" approach should include elements to ensure supply of essential medicines, through the provision of a procurement and supply chain action plan.

Financing

Focus on coordinated actions that use and support domestic financing systems where possible. This could include pooling of funds, using common pay scales, and ensuring funding for critical inputs required for service delivery.

Ensure that interventions always support financing policies based on the principles of movement towards UHC.

Consider the use of cash and voucher assistance, while ensuring these do not inadvertently contribute to a fee-charging culture and undermine progress towards universal health coverage.

Leadership / governance

Ensure inclusion of marginalised or vulnerable groups such as persons living with disability, women and children in planning and monitoring of services.

Instead of channelling funding to vertical programmes that operate in silos, work with the locally organised coordinating bodies (i.e. governments where functional, or other coordinating structures where government is non-functional) to foster better coordination and more effective resource allocation.

Make initiation and modification of projects in FCAS simpler and faster so as to respond more effectively to the transient nature of problems in such contexts.

To enable more adaptive programming in FCAS, make Monitoring and Evaluation requirements more flexible and adaptive to cater for changes that might arise during the implementation.

Provide transparent and publicly available annual reporting by FCDO on the progress made and results delivered against the HSS paper, *Strategy for International Development* and the EPD action plan.

Utilise governance and board positions on major development banks and multilateral organisations to ensure aligned and coordinated approaches to HSS in FCAS among major global health actors.

Avoid interventions that create parallel service delivery during emergencies and provide systems support (when system strengthening is not feasible), working through existing systems by providing equipment, supplies, drugs and human resources, rather than replacing these systems (which tends to weaken them).

Gender equity

The following steps should be taken to infuse post-conflict and crisis decision-making with a focus on gender equity:

Policymakers and healthcare providers should identify the different health needs of men and women resulting from conflict. Appropriate indicators should be used, including data that is broken down by sex. Consultation should take place with the people affected by conflict – and this should include women.

Policymakers and healthcare providers should understand why men and women's health needs differ. Health is not only influenced by biology but also by the gender norms that undermine women and girls.

Respond to these differences effectively both in providing healthcare and in restructuring the health system.

3 In light of the *EPD Paper*

Fund common goods for health, such as surveillance and monitoring, which are key to shock-preparedness.

Support effective essential health service packages, including essential drugs.

Support integration of nutrition actions into the package of essential health services as part of national health plans and UHC roadmaps and ensure these are aligned with national multisectoral nutrition plans as part of a 'health in all policies' approach with nutrition at its heart.

Prioritise humanitarian cash and voucher assistance in order to increase household income. This can reduce negative coping mechanisms (such as incurring debt) and ensure that households have purchasing power to access nutritious food.

Increase uptake and utilisation of acute malnutrition adaptations such as simplified treatment protocols, training families to screen for acute malnutrition in their children and creating tools for people with low literacy.

Reach excluded groups and take into account the specific impact on children, in particular vulnerable groups, with close attention to populations already in crisis or with worse levels of acute food insecurity.

6

Summary and conclusion

6 Summary and conclusion

Global health is a priority within FCDO's *Strategy for International Development*, and the FCDO's *Ending Preventable Deaths* paper highlights how those living in fragile and conflict-affected settings are at higher risk of preventable death. FCDO's *Health Systems Strengthening* paper highlights the need to undertake HSS in FCAS. The rationale for this is clear, as 75% percent of people living in extreme poverty live in FCAS and key indicators of health system functionality provide evidence of a fundamental weakness in healthcare access, quality and health outcomes.

Healthcare systems in FCAS have to operate in unstable, highly fluid contexts where there are multiple risks. They are characterised by service delivery that is often fragmented across multiple providers, with weak alignment and coordination. There are often staff shortages, unequal pay across organisations and unequal labour distribution across geographic locations. Challenges collecting and accessing data undermines strategic and adaptive decision-making. Limited access to essential medicines due to production, procurement, importation and logistics challenges further undermines ability to respond to critical health needs. Short-term, siloed funding that is subject to various donor rules – and an overall lack of strategic coordination across government, funders, healthcare providers and users does not aid the fostering of adaptive and resilient health systems.

To respond to these challenges, health systems within FCAS need to be resilient to shocks and stressors. Evidence shows that essential healthcare packages that are demand driven and community driven, and locally adapted as the context changes, improve child health outcomes. Basic healthcare packages have also been shown to help improve access to essential medicines. It is also vital to ensure that healthcare and community healthcare workers are paid based on common pay scales, regardless of the healthcare provider, and that training is provided and working conditions improved. Also essential is safeguarding financing for critical foundation health system functions that focus on universal health coverage. Strong district level health system management has been shown to improve service delivery and resource utilisation. Finally, gender-equitable benchmarks across the different building blocks of the health system can help to track progress in improvements in health systems reform.

In support of FCDO delivering its commitments to global health and to its EPD and HSS priorities, we recommend that priority is given to building resilient, adaptive, gender-sensitive health systems in FCAS, an approach that would benefit from longer-term funding cycles. This should include a focus on providing essential health service package approaches through strong coordination across governmental authorities (where they exist), donors, healthcare providers and users, to ensure UHC, health surveillance and monitoring.

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