Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected Fragile States

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Alliance for Health Policy and Systems Research

Research Issues 1

Key Messages

- Conflict-affected fragile states have some of the worst health indicators in the world and are farthest from meeting the Millennium Development Goals (MDGs). Moreover, their characteristics make it challenging to accelerate progress against the MDGs. They have very low and often declining economic growth, and high rates of relapse into conflict.
- There is a scarcity of research into their health systems, and on how to work effectively within their governance and resource constraints, despite the fact that more effective health services are urgently needed.
- It is important to do more research to improve the health outcomes of conflict-affected populations, and to improve the efficiency and effectiveness of service delivery in these very resource constrained settings.
- Innovations in the organization and management of health service delivery and financing in conflict-affected environments should receive more substantial health policy and systems research. More research is also needed on the effectiveness of aid with respect to the health system, and the links between health, governance, and state building.
- While research can be high risk due to security and governance concerns, the yields, in terms of contributing to substantial improvements in health systems strengthening, and improvements in health service delivery and health outcomes, justify the investment. Lessons from innovations in post-conflict states can also be applied to health service delivery in more stable, low-income countries.

Significance of conflict-affected fragile states

As a result of their extremely poor health indicators, fragile states have recently become prominent on the international health agenda. These countries are furthest from reaching the MDGs, and continue to lag far behind other comparable countries. Whilst they are home to only 20% (or 1 billion) of the world's population, they contain a third of the world's poor, a third of the world's maternal deaths and a third of those living with HIV/AIDS (World Bank, 2007). They have very high rates of under-5 mortality, and very low levels of government health expenditure compared to other low-income countries (Figure 1). This briefing note focuses on the four-fifths of fragile states which have been or are still engaged in conflict, all of which have disrupted health systems.

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Definitions

Different terms have been used to describe states that face particularly difficult conditions. They have been referred to as fragile states, failed states, difficult environments, difficult partnerships and low-income countries under stress. Fragile states have been defined by the UK Department for International Development (DFID) as states that are unwilling and/or incapable of delivering basic services to their populations. Fundamental to all fragile states (or situations, as areas of fragility can exist within stable states) is the lack of effective political processes to influence the state to meet social expectations. Other characteristics include weak institutions and governance systems. Most experience conflict, but not all fragile states experience endemic violence. All suffer from poor governance and limited administrative capacity. Post-conflict countries suffer from high rates of relapse to conflict, with a 44% chance of a return to conflict within five years. Conflict has very severe effects on economic growth; most fragile states have growing levels of extreme poverty, which is opposite to the trend in most low-income countries. Many development partners have their own list of fragile states based on various parameters, including risk of conflict, accountability of government institutions, capacity to manage public resources and deliver services, territorial control, levels of poverty and ability to protect the poorest. This paper uses the World Bank's 2007 list of 34 fragile states. They have been classified into four typologies: (1) prolonged crisis or impasse (eg. Myanmar, Somalia, Zimbabwe); (2) post-conflict or political transition (eg. Democratic Republic of the Congo, Liberia, Southern Sudan); (3) gradual improvement (eg. Burundi, Cambodia); or (4) deteriorating governance (eg. Côte d'Ivoire). Each year the lists are revised, so fragility is a status, not a permanent classification.

In 2004, the High-Level Forum (HLF) on the health MDGs brought together the World Bank, the World Health Organization (WHO), bilateral donors, and ministers of health and finance, to discuss how to achieve the health MDGs. The HLF identified fragile states as a key topic of interest, and produced several seminal papers (High Level Forum, 2005). Overall, it was found that, similar to lower-income countries (Travis *et al.*, 2004), there is a need to strengthen the health systems in fragile states if they are to accelerate progress against the MDGs.

Despite recent attention to both conflict-affected fragile states and health systems strengthening, there is very little health policy and systems research (HPSR) that can be used to inform policy and practice in conflict-affected fragile state environments. Most of what is empirically known is based on stable, low-income countries. In conflict-affected fragile states, delivery and scaling up of health services is more difficult than other low-income settings due to poorer governance, and severe human resource and financial constraints. For example, by the end of the war in Liberia, there were fewer than fifteen physicians left, and 80% of the health services were provided by nongovernmental and faith-based organizations. Resource constraints are further exacerbated both by a contested policy environment and a reliance on international aid, which results in extremely volatile funding. It also makes harmonization and alignment more challenging to the detriment of aid effectiveness. It is thus difficult, and sometimes inappropriate, to apply lessons and recommendations from low-income countries to conflict-affected fragile states.

The ten countries with the highest under-5 mortality rate in the world, together with their per capita government expenditure on health (UNICEF, 2008; WHO, 2008b).

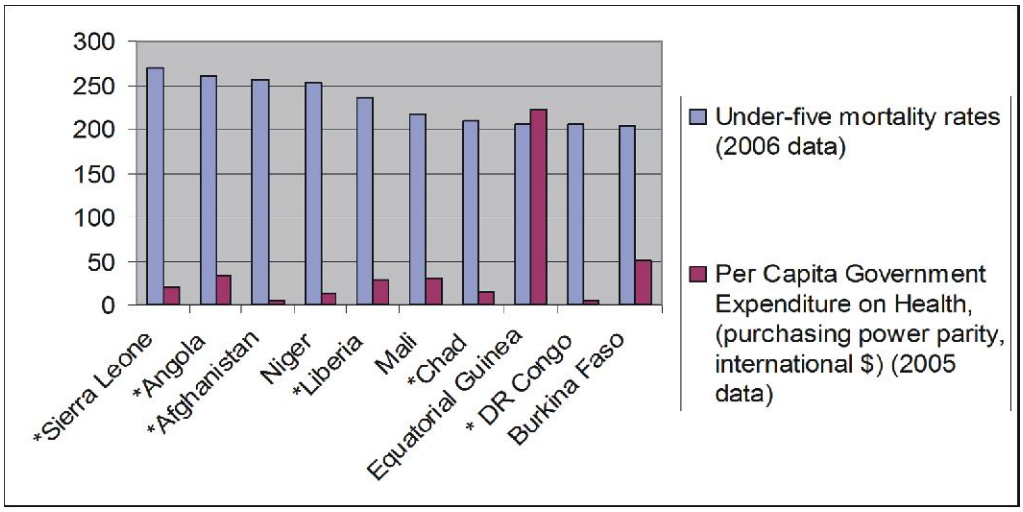


Fig. 1

* Conflict-affected fragile state (World Bank, 2007).

In general, fragile states are unduly underfunded by the international community, which results in restricted health budgets (McGillvray, 2005). A recent study that analysed aid volumes and volatility to fragile states between 1992 and 2002 found that controlling for population, poverty and performance, fragile states receive around 40% less aid than predicted (Figure 2) (Dollar & Levin, 2005). The volatility of aid undermines strategic health planning, and makes it difficult to address capacity deficits.

By demonstrating which health systems strengthening approaches work in what contexts, research in conflict-affected fragile states could contribute to improving the extremely poor health status of their populations. Operational research on innovative responses to fragile environments is needed if health systems and services are to be expanded and sustained. There is a need for research into approaches to increasing coverage of marginalized and vulnerable populations; strengthening the resilience of communities and local health services; developing new models of service delivery and performance-based financing; and working effectively with non-state providers who often deliver the majority of services in fragile states. In addition, the aid environment and policy processes should themselves be examined given their influence on health programming and, ultimately, health outcomes.

Actual versus appropriate aid per capita flows to fragile states (1992–2002) (DFID, 2005).

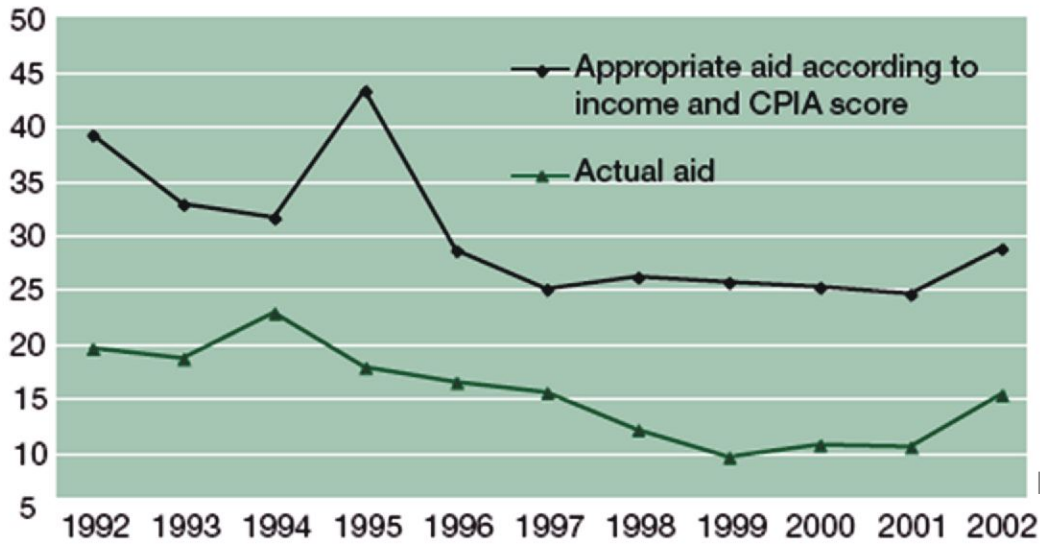


Fig. 2

A neglected area of research

While support for health systems research in low- and middle-income countries is limited, in fragile states the lack is even greater. Foundations, which are a large source of research funding, tend to have very specific areas of interest, typically defined by their mandate. Few of the many foundations, donors and agencies involved in supporting health research list fragile states as a priority. The Andrew W. Mellon Foundation was a notable exception in that it funded several large programmes on health issues in conflict, and stimulated valuable research on forced migration and population health. Unfortunately, the programme ended in the late 1990s, and this important gap has not been filled by others.

Bilateral donors, such as DFID, USAID and AusAID, and multilateral agencies such as the World Health Organization and the World Bank, fund occasional research on health in fragile states, but to date there has been no systematic approach to addressing knowledge gaps. Most research is commissioned according to donor-specific needs, often linked to specific projects; key research areas are not systematically identified or funded. Bilateral donors are increasingly interested in fragile states because of their poor health indicators, and concern about their potential national security implications. For example, the DFID Research Strategy explicitly identifies fragile states as an important area where more research is needed; yet health systems research in fragile states is not identified as a priority.

Research on health systems in conflict-affected fragile states tends to be piecemeal and small scale, and there is a dearth of policy-relevant insights and analyses. Within the humanitarian field, despite the substantial literature on aid, refugees and internally displaced people, as well as on disease-specific issues, little attention has been paid to health system and policy issues.

Recent literature reviews on health system issues reveal very few papers that assess health interventions or examine health systems issues in fragile states. In a paper on equity, health and fragile states for the WHO Commission on Social Determinants of Health, only a handful of papers were found, and most were descriptive, with limited data presented (Ranson *et al.*, 2007). Out of 28 reports in the health-financing literature that they examined, Palmer and co-workers (2006) found 4 on fragile states. A follow-up study on user fees found 2 studies of 16 that focused on fragile states (Lagarde & Palmer, in press).

On average only one to two papers per year describe innovative approaches to health service delivery in conflict settings, or examine challenges in post-conflict health systems reconstruction (see eg. Barnabas & Zwi, 1997; Pavignani & Colombo, 2001). What little literature there is tends to be descriptive case studies. While these can be useful for sharing policy-relevant lessons, most do not seek to address a specific research question, and they are generally not conducted using rigorous research methods.

Why is research on health systems in conflict-affected fragile states neglected?

While funding constraints have certainly led to neglect of research in conflict-affected fragile states, other factors have also contributed to this underinvestment:

- a lack of research champions amongst people who work in fragile states as well as academics;
- a weak culture and history of conducting research due to the perceived risks and difficulties of conducting research in these settings;
- limited capacity to undertake the kind of analytic research that is needed;
- a lack of access, as some states do not welcome donors, researchers or nongovernmental organizations (NGOs), except in very limited circumstances.

People who deliver health services in fragile states and conflict-affected settings are typically focused on saving lives and improving services in challenging, rapidly changing contexts. They tend not to conduct or advocate for research, partly because they may lack the mandate, skills or funding to do so. Few NGOs or UN agencies would be in a position to conduct longitudinal research on health systems issues, as most are project-oriented. Many donors active in fragile states do not fund research on health systems. The different priorities, approaches, time frames and funding streams for humanitarian and development agencies in post-conflict contexts (both NGO and donor) also contribute to the problem.

Academic researchers find the context difficult and unappealing due to security and other concerns. It can be expensive to collect data due to complex logistics caused by poor security

and infrastructure, and researchers are unable to supplement primary data collection with data collected for other purposes because such data are often absent, with the exception of one-off surveys. It is difficult to do multiyear, longitudinal studies due to insecurity and travel restrictions, some imposed by universities to reduce risk. There may even be a perception that there is no health system per se to research.

In-country capacity for research is often extremely limited. A well-known impact of unstable environments is an exodus of skilled personnel – health professionals and academics may be among the first to leave given their greater mobility and marketable skills. Research institutes tend to be weak as they have limited funding, limited international engagement and suffer from a drain of their best researchers to better-funded organizations, including the United Nations and NGOs. A requirement by many northern funding agencies that academics link up with in-country academic partners for capacity-building processes may create its own difficulties given the few partners with whom to work and the limited ability of those that do exist to take on additional projects.

Together, these factors, when combined with a lack of funding, have the practical result that health systems researchers who work in developing countries tend not to work in fragile states.

Research on health in conflict-affected fragile states would make a difference

Many of the broad lessons about health systems strengthening and policy making are applicable in fragile states. But poor governance, conflict, extreme poverty and limited resources mean that approaches must be adapted. In addition, there are certain innovative health service delivery and funding mechanisms (such as nationwide contracting out of NGOs to deliver services) that may be specific or particularly common to conflict-affected fragile states. Their comparative advantage over other delivery and financing mechanism in conflict-affected environments needs to be examined (see box). Because post-conflict countries are often forced to innovate, lessons from such environments may also be usefully applied in more stable low-income countries.

Another reason research is important is that improved efficiency and effectiveness are essential to maximize scarce resources. Establishing the evidence base in these settings is crucial given the paucity of resources and human resource capacity. In addition, although research may be high risk, it has the potential to yield high returns; given that health indicators are so poor and health systems so dysfunctional, even marginal improvements can have significant positive health impacts. Substantial improvements can be rapidly achieved in such environments. For example, in Afghanistan, a rapid increase in population coverage with a basic package of health services has resulted in significant improvements in health indicators. Finally, donors and practitioners can be influenced by political and ideological objectives, with national governments in a weak position to respond. Building up the evidence base with which to inform programming and investment would promote policy accountability in a time of heightened vulnerability and marginalization.

Contracting out

Contracting out service provision to NGO providers has been used as a means to rapidly scale up services in current and former post-conflict countries such as Afghanistan, Cambodia, the Democratic Republic of the Congo and South Sudan (Loevinsohn and Harding, 2005). Innovative approaches to setting up, managing and regulating contracts have been developed, but this experience is rarely published, leading to limited dissemination and discussion amongst practitioners and policy-makers. For example, how effective is 'within government' contracting (as is being done in Rwanda)? And is this a model for other countries? Key questions centre on the types of contracts, the contracting process, regulation of contracts, and impact on service delivery (quality, efficiency) and health outcomes. The role NGOs and the adaptations they must make, performance-based financing, and the effect on equity and the importance of trust are additional topics that need further research (Palmer *et al.*, 2006). There are also specific human resource concerns, including how to set salaries at the nationwide and local level in order to ensure that contractors have equal access to staff; how to encourage staff to work in remote areas; and how being contracted (and not being a civil servant) affects job security. Given the expansion of contracting out to countries with substantial populations, it is important that the contracting process be examined in much more detail to maximize effectiveness and, ultimately, health outcomes.

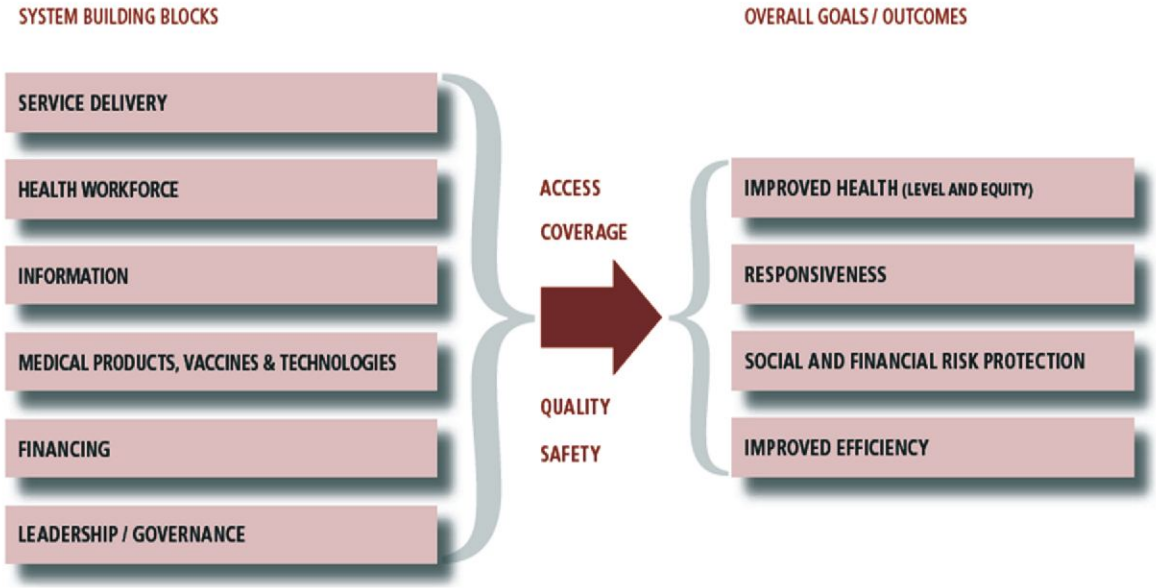
Research topics can usefully be divided into three main areas: health systems strengthening, the aid environment, and the role of the health sector in state building. Research should be undertaken in a range of different types of conflict-affected fragile states, including those currently affected by conflict (acute or chronic), those emerging from conflict with attendant post-conflict challenges, as well as chronic underperformers or deteriorating states.

Two caveats should be applied to this research agenda. First, it is not a comprehensive research agenda but rather a list of illustrative research questions presented here to stimulate further discussion and consideration of the issues. Second, this agenda was not reached through a systematic priority-setting process but rather reflects the views of a limited number of experts in the field. It was informed by a follow-up meeting of academics and health advisors held after a joint London School of Hygiene and Tropical Medicine and Merlin Conference in October 2007 on delivering health care in fragile states, as well as by reports and articles on the topic (Banatavala & Zwi, 2000; WHO, 2007a).

Strengthening fragile health systems to deliver key services

WHO offers a framework with six system building blocks considered necessary for health systems functioning: services delivery; human resources for health (health workforce); information; medical products, vaccines and technologies; health financing; and leadership and governance (WHO, 2007b). Adequate performance in all areas is needed if a health system is to be effective in terms of access, coverage, quality and safety, and ultimately if it is to promote improved health and equity and achieve greater responsiveness, efficiency and risk protection. The health system building blocks are used below in presenting key areas for research.

Service delivery and basic packages Basic packages (also known as essential health packages), centrally defined and costed, and based on cost-effectiveness and burden of disease, have been used particularly in post-conflict states. While there is a substantial literature on the costing and use of basic packages, evidence on effectiveness is mixed (Doherty & Govender, 2004). Packages may not work well in conflict-affected fragile states, especially those which are chronic underperformers and may not be able to deliver the political will and joined-up decision-making necessary for implementation (WHO, 2008). It is thus important to examine the effectiveness of implementation in fragile states, together with mechanisms of implementation (eg. contracting providers to provide the essential package or government provision supported by clinical or quality assurance protocols; regulation and accreditation of individual facilities; supervision; and, allocating inputs to deliver package). The extent to which contracted providers also have a responsibility to build capacity, and how they do so, also warrants attention. The methodology for costing basic packages deserves more research, particularly in post-conflict countries where basic packages are being proposed and budgets are being set based on the assumptions that costs are similar between countries and that sustainable



financing is available. Finally, equity concerns, and the differences between rural and urban settings should be examined (Doherty & Govender, 2004), including how the use of non-state actors affects equitable provision of health services.

Service delivery and role of vertical programmes The tension between quick wins and systems building remains unresolved (Atun, Bennett & Duran 2008). The argument for vertical programming is strong(er) where the state is unable or unwilling to deliver services, but what are the implications of long-term underfunding of the overall health system? What is the potential for vertical programmes to contribute to health systems strengthening more generally in conflict-affected fragile states? Studies into how vertical and horizontal programmes intersect would shed light on how aid could be organized more effectively to improve health outcomes. A relevant question might be to examine how vertical programmes have intersected with the contracting out of primary care, as in Afghanistan. A related question could focus on the best way for vertical programmes to help build the human resources base within fragile state settings.

Service delivery and non-state actors Little is known about how best to work with non-state actors, which include international and national NGOs, United Nations agencies, and private sector actors such as drug sellers, traditional practitioners and other private providers. How can non-state providers contribute to improved health services through delivery of a basic package (via contracting or other mechanisms) or improved referral mechanisms? There is also the potential to examine in more detail the use of franchising, vouchers, training and regulation, and social marketing in fragile states. What "better practice" has been instituted by NGOs and how can this be built upon to feed into health systems strengthening post-conflict (Laurence & Poole, 2005)? In some situations, it may be necessary to work with rebel groups which provide health services. It is not clear what role international actors should play in mediating relationships between governments and rebel groups to enable service delivery.

Information and medical products Basic information is often lacking in conflict-affected settings, despite the multiplicity of actors, and the need to assess health status, human resources and health seeking behaviour. Improved field epidemiology tools, such as survey and surveillance methods, must be developed and tested. It is also necessary to rebuild health information systems, which often requires the engagement of many actors, and in turn consultation, coordination and longer-term investment. What is the evidence for reconstructing health information systems, and how could existing surveillance systems and/or monitoring and evaluation systems be scaled up in a cost-effective manner? In terms of medical products, what are the best ways to set up and manage purchasing systems and supply chains? Should vertical procurement systems be integrated into national systems, and how should this be done? Studies on health care seeking behaviour and on service use would also provide insights into accessibility, quality and trust in health service providers and services.

Health Workforce Human resources for health are a key issue in fragile states as they suffer major losses of personnel and have significant difficulties in retaining staff in peripheral areas. Similar to other low-income countries, questions include how to attract, retain and develop health staff (Doull & Campbell, 2008). During conflicts, health-care workers end up being trained by many different organizations and systems, e.g. health workers living in refugee camps or working with humanitarian NGOs and United Nations agencies. This raises questions about how training could be standardized and accredited so that staff can be more easily absorbed back into government systems once the conflict is over. Post-conflict, questions include how to ensure payment of salaries; improve living conditions; promote trust and enhance morale; accelerate training of health staff in accredited institutions; promote continuing education and professional development; and reintegrate NGO-trained health workers into government (or contracted-out) health systems – all within a context of uncertain security and stability. There are also questions about the role of community health workers, and how task-shifting can be used to fill human resource gaps. Retaining skilled personnel and reducing the push factors which lead to the out-migration of skilled personnel is a major issue; innovative thinking about how to attract back those who have left the country with their skills is another major challenge.

Health financing The evidence base on health financing for developing countries is weak (Palmer *et al.*, 2004), albeit better developed than many other health systems areas. Research on the different health-financing options (eg. user fees, health equity funds and community-based health insurance) used in fragile states would be of value. User fees are commonly employed and advocated by donors and national governments, although even small financial payments can be a significant barrier for very poor populations (James *et al.*, 2006). By the same token, in contexts where the government is not able to pay salaries, user fees may be the only available source of financing for the health system, especially at the periphery. While some agencies, such as DFID, now advocate their removal, little is known about how to withdraw user fees in a way that minimizes negative impacts on service delivery. It is likely to be more difficult in conflict-affected states than in low-income countries due to the fragmentation of the health sector, which means various actors have to agree to remove fees. In addition, the banking system is often rudimentary or nonexistent, so it can be difficult to disburse money (for salaries and recurrent costs) to local health clinics in a timely manner.

Leadership and governance To be effective, a health system must have strong leadership. This should reside with the government, but in fragile states, central leadership can be weak or perceived as illegitimate, and many actors, such as donors, WHO and NGOs play leadership roles. Such a situation contributes to confusion and undermines government leadership. There is almost no research on what leads to strong leadership within a government, and the formulation of legitimate policy-making processes. How can international health actors better support ministries of health and encourage improved governance? What roles do donor harmonization and alignment play? What is the role of NGOs and other non-state providers in providing support? Studies to identify why there is poor leadership and competition amongst many key health actors (including donors), and ways to overcome this, are required. Also, what role might be played by efforts which ostensibly should harmonize engagement, including trust funds or sector-wide approaches such as the International Health Partnership, and what is the impact of conflict, poor governance and volatile aid on these mechanisms?

Does the aid system best serve health systems strengthening?

Conflict-affected fragile states are often particularly aid-dependant. Many questions centre on how best to allocate and manage donor funds within the health sector, using a variety of aid instruments. The speed with which aid mechanisms are set up and their effectiveness in disbursing funding have enormous implications for health service delivery. Earmarking, the types of health interventions funded, the amount of pooled funding and the volatility of funding flows also impact the planning and management of health service delivery (Vergeer, Canavan & Bornemisza, 2008; Leader & Colenso, 2005). Funding continues to be insufficient and volatile, despite the OECD-DAC's Principles of Good International Engagement in Fragile States (Fragile States Group, 2005). This makes it extremely difficult for ministries to plan and implement activities that will strengthen the health system. The reasons for aid volatility are known (McGillvray, 2005), but its impact on the health sector has not been measured. For example, why is there often a transitional funding gap that occurs when a country transitions from conflict to post-conflict? What is the impact of this on health services and outcomes, and why do relief and development funding streams continue to be separate?

Aid mechanisms also impact the ability of donors to harmonize with each other, and align with government priorities. There is a need to examine disincentives to harmonize and align, which are particularly important when resources are scarce (Christiansen, Coyle & Lockhart, 2004; OPM/IDL, 2008). Also, given the preponderance of vertical funding in many fragile states due to state avoidance, how does vertical funding integrate within a strong, primary care approach such as that taken in Afghanistan?

Health, governance and state-building

There is growing interest in exploring the intersection between health, governance and state-building, due to current concerns about global and national security. Service delivery is seen to be one way of fulfilling the social compact between society and the state, and therefore enhancing legitimacy, governance and ultimately state-building (Eldon, Hadi & Waddington, 2008; Jones *et al.*, 2008). However, the dynamics of this interaction remain unexplored, and conceptual frameworks are underdeveloped.

Donors may direct their funds outside of state structures, and do so for a variety of reasons: to avoid engaging with a state

whose international legitimacy is questioned, or whose ideological basis is not attractive to the donor; to increase the pace at which funds can be disbursed and locally utilized; and to promote wider engagement among actors within the health sector. One downside of such approaches is that they make no contribution to building state leadership and governance capacity. This potentially has significant sustainability implications.

In post-conflict states both health sector reconstruction and state-building are important objectives. Investments in health systems may provide opportunities to contribute to building a more effective and accountable state; conversely, a failure to build an effective state will undermine investments in health systems. The literature on this subject is negligible, despite its growing importance in the development agenda (GSDRC, 2007). There are a number of important questions to be answered. How does poor governance, conflict and the tendency to recidivism affect health sector rebuilding and health systems strengthening? And how does the development of health systems affect issues of trust and re-building? For example, given the increasing prevalence of contracting out, it is important to examine the effect of contracting on political legitimacy and governance. How does the community perceive contracting in terms of who is responsible for, and able to deliver services, and what does this mean for governance and state stability? How does civil society hold non-state health service providers to account? Does the use of non-state providers – e.g. through contracting – disrupt the social compact between a society and its government, and does this have an impact on state-building? And finally, what is the impact of the state-building agenda on the provision of health services as a human right? Conceptual frameworks from which to analyze these questions, and test them in the field would be an important first step in assessing how aid to the health sector in conflict-affected fragile states could help achieve state-building objectives. Tools such as the "Health and Peace Building Filter" may offer some guidance on the issues to consider in planning and programming health-related activities in fragile settings. This places some emphasis on cultural and conflict sensitivity, and the promotion of trust, gender equity, social justice and social cohesion, as well as good project and programme accountability and governance structures (Grove & Zwi, 2008).

Redressing the neglect

It is important to conduct more health systems and policy research in conflict-affected states. While lessons can be learnt from health policy and systems research from non-fragile states, they have to be adapted to conditions in conflict-affected states. Despite the risks, investment in research in these environments can deliver high returns. It is increasingly apparent that meeting the MDG targets requires more effective approaches in these settings. Learning as much as we can from prior experience, and undertaking more rigorous and consistent research on various innovative approaches to service delivery in the health sector, would substantially contribute to enhancing the potential to reach the MDG targets. Research is particularly needed to address the crucial relationship between health systems strengthening and wider governance issues.

To move this agenda forward, three key actions are proposed. First, a more robust research agenda should be developed based on the preliminary research agenda outlined here. A workshop for practitioners, researchers and donors interested in this area, complemented with a Delphi prioritization process, would bring together available insights and experience, and identify priority research needs and further refine the research agenda. One way to take this process forward would be via the "Health and Fragile States Network" which is a newly formed network of donors, NGOs, United Nations agencies, academics and ministries of health that aims to stimulate policy and research (see box on following page). In addition, agencies and donors who work in fragile states must be encouraged to commit not just to building up the evidence base but also to developing a culture which critically examines and reflects on emerging experience, and stimulates more rigorous research.

Second, more substantial funding is required for enhanced investment in researching how best to promote the achievement of the health MDGs in conflict-affected fragile state settings. This could be linked to specific programmes where the evidence base is weak (for example the removal of user fees), and where robust studies (i.e. longitudinal, case-controlled and planned during the design of programmes) would be particularly helpful. It would be valuable to provide funding and academic support to countries to document local experiences of organizing and delivering services in fragile environments, ensuring the alignment and coordination of donors (and the difficulties in doing so), vertical versus horizontal programmes, human resources for health, and financing options, and innovations that include approaches to removing user fee systems. It would also be useful to expand existing monitoring and evaluation budgets, as this type of work can contribute to the evidence base. Researchers and practitioners need to develop strategies to mobilize more substantial resources for research in this field, encourage the development of a research culture and advocate for the addition of this neglected topic to the global health research agenda.

Health and fragile states network

To help address the challenge of providing health services in conflict-affected fragile states, a new 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 to best organize and finance health services in these environments. The Steering Committee consists of representatives from DFID, the European Commission, HealthNet TPO, the International Medical Corps (IMC), the International Rescue Committee (IRC-UK), Merlin, Save the Children United Kingdom, the University of New South Wales Sydney, UNICEF, the World Bank and WHO. The secretariat is hosted at the Conflict and Health Programme at the London School of Hygiene and Tropical Medicine. The network is aimed at health professionals and others interested in health issues and health systems strengthening in fragile states. For more information, visit www.healthandfragilestates.org or email health@healthandfragilestates.org

Third, donors that fund research need to develop more flexible approaches. They should create more responsive funding lines focused on health and fragile states that would allow academics to apply for funding based on a systematic assessment of research needs. It would also be useful to encourage key donors to support the establishment of a number of research centres, and an effective research network, with an emphasis on health in fragile states, as funded previously by the Andrew Mellon Foundation. This would enable teams of researchers with specific expertise to be developed, and fostering of links over time between northern and southern academics. Flexibility regarding the common requirement to link to southern research partners is also needed, as there may be limited local institutional partners.

To conclude, more robust health systems research in fragile states would improve service delivery and health outcomes amongst populations who have some of the worst health indicators in the world. The analysis of existing experience and the establishment of key research initiatives would add value to efforts to improve health and health systems, and deliver on the MDG targets in fragile environments.

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- Promote the dissemination and use of health policy and systems knowledge to improve the performance of health systems;
- Facilitate the development of capacity for the generation, dissemination and use of health policy and systems research knowledge among researchers, policy-makers and other stakeholders.

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