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From Humanitarian and Post-conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs

The U.S. Agency for International Development's strategy for fragile states recognizes the importance of providing health and other key social services as part of humanitarian emergency response and post-conflict interventions (USAID 2005). Concentrating on health needs is critical for dealing with immediate epidemiological crises (Checchi et al. 2007), restoring state functioning, and contributing to reducing the sources of fragility, such as social exclusion, low state legitimacy, and weak state effectiveness (Brinkerhoff 2007a, Jones et al. 2006). Among the challenges donors face in providing health sector assistance to fragile states is moving from emergency assistance to programs designed to support long-term health sector goals and capacities. As Waldman (2006: 18) notes, "there is not much experience in the health sector with what might be called transitional programming."

Mozambique/Jill Claus

This policy brief focuses on the transition from emergency assistance and relief to strengthening the health system for the long term, and the role of nongovernmental organizations (NGOs) and how they can help fragile states to rehabilitate their health systems. As Box 1 illustrates, there is general agreement on the broad features of state fragility, but as a category it contains significant variation. Thus, transition strategies and interventions need to be contextualized for particular country situations.

HEALTH SYSTEMS IN FRAGILE, POST-CONFLICT STATES: A COMPOSITE VIGNETTE

In fragile states, particularly those that have experienced extended periods of conflict, health systems have typically been seriously eroded and damaged. Health infrastructure is destroyed, or is not functional. Services are fragmented and ad hoc, differentially available depending upon where conflict-affected areas are located. Financial resources become scarce; for example, during El Salvador's civil war, per capita health spending dropped by 50 percent (Waters et al. 2007). As public finance for health declines, private spending on health increases, and unpaid health workers shift to private practice. Better-off citizens may still be able to purchase care, but the poor and marginalized have fewer options, obtaining care wherever they can, and increasing their use of traditional

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HEALTH SYSTEMS 2020

BOX 1. CHARACTERISTICS OF FRAGILE STATES

The majority of conceptualizations of fragile states treat fragility as a question of degree between two poles: state failure and collapse at one extreme (e.g., Somalia), and states characterized by serious vulnerabilities at the other (e.g., Pakistan). Most characterizations concur that fragile states have governments that are more or less incapable of ensuring basic security for their citizens, fail to provide basic services and economic opportunities, and are unable to garner sufficient legitimacy to maintain citizen confidence and trust. Fragile states have citizens who are polarized in ethnic, religious, or class-based groups, with histories of distrust, grievance, and/or violent conflict. They lack the capacity to cooperate, compromise, and trust. When these capacity deficits are large, states move toward failure, collapse, crisis, and violent conflict. Post-conflict and recovering states need to identify and pursue pathways to rebuilding capacity and filling deficits, and to avoid the ever-present risks of backsliding.

Source: Author

healers. Corruption flourishes. The health system suffers a loss of human resources as medical personnel and management staff flee for their safety, are menaced or killed, or even if they remain are unable to provide services due to lack of medicines and ruined facilities. In Mozambique, rebel forces targeted public health professionals along with infrastructure as part of their war-fighting strategy, with decimating effects, especially in rural areas (Pavignani and Columbo 2001). Health policy, planning, and management capacities wither and weaken as well, leaving the health system rudderless, with little direction, diminished authority, and low legitimacy. The cumulative effects of two decades of conflict in Uganda, for instance, meant that the new Museveni government took control of a collection of debilitated and hollow state institutions. The institutional vacuum in the health system took years to fill until the government was able to establish a coherent and viable health policy and operational framework (Macrae et al. 1996). Similarly, in Afghanistan, protracted periods of instability and war further undermined the already extremely weak health system, which has relied upon external support since the 1950s (Jones et al. 2006). Only recently has the health ministry been in a position to take steps toward creating national policies and operational frameworks.

HEALTH INTERVENTIONS IN FRAGILE STATES

In response to the humanitarian crises in fragile, post-conflict states, the international community has mobilized to provide assistance. In the health sector, post-conflict assistance focuses on three targets of intervention that are broadly sequential (see Waters et al. 2007):

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

Meeting immediate health needs falls at the core of humanitarian and complex emergency crisis response, and international NGOs are at the forefront around the world, in some cases providing services while conflict is still underway, not simply following cessation of violence. As experience in Liberia, Mozambique, Sierra Leone, and Timor Leste demonstrates, interventions call for rapid ramp-up, urgent infusion of resources and capacity, and concrete results, as the provision of health (along with other services) is one of the critical demonstrations of the transition to peace (see Pavignani and Colombo 2001, Vaux and Visman 2005, OECD 2008).

After the urgent crisis for conflict-affected populations has been addressed, the next phase of assistance shifts to designing a cost-effective package of basic services, setting priorities (e.g., getting services to marginalized and/or underserved groups, targeting at-risk populations) and establishing delivery mechanisms. NGOs also play a role here, and an increasingly popular approach is for donors and country health ministries to contract jointly with NGOs for provision of a basic package of health services. The government of Afghanistan and its donor partners have applied this, as has Southern Sudan and more recently the Democratic Republic of Congo (see Roberts et al. 2008).

From investments and assistance to restore essential services emerges attention to institution building for the health system. This phase of rehabilitation considers the range of functions, resources, and capacities necessary for an effective and sustainable health system. It includes, for example, health data collection and analysis, sector and program priority-setting, health financing, capital

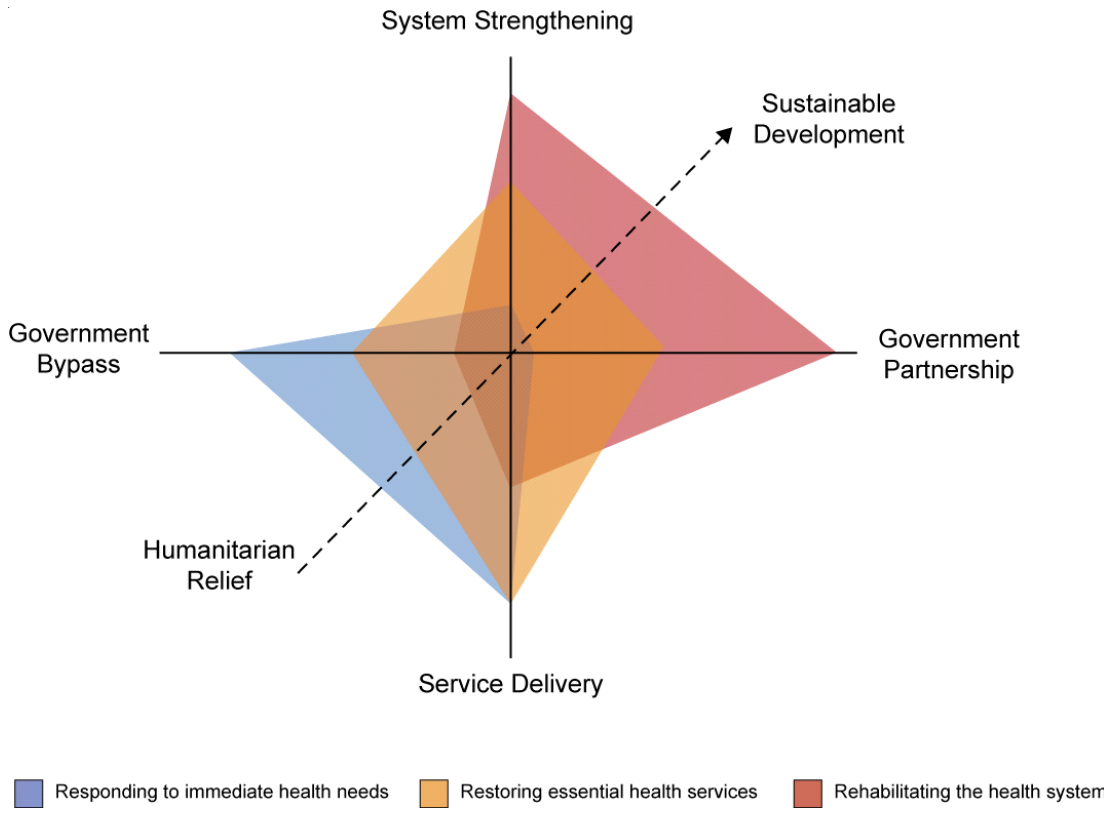
investment for infrastructure, policy-making and regulation, workforce planning, training and education, and long-term operational capacity. Health governance surfaces as a concern, along with governance more generally (Brinkerhoff 2007b). In many countries, good health governance – which includes evidence-based policymaking, transparency and accountability, and citizen participation in influencing service priorities and delivery – was weak prior to the emergence of conflict (Brinkerhoff and Bossert 2008). Thus rehabilitation often means creating new elements of the health system, not restoring something that existed previously but was damaged during conflict.

The public health system, as a component of the state, needs to develop legitimacy in the eyes of citizens and be seen as effective, responsive, accountable. This third transition phase puts a premium on capacity building of the health system to enable public health actors to prepare budgets and plans, administer grants and contracts, manage human resources and facilities, handle medicine and equipment logistics, and so on. For example, in post-war Ethiopia, donor willingness to channel rehabilitation resources for essential drugs through the health ministry helped the new government establish its legitimacy, as well as facilitating a quick return to basic services provision through local health facilities (Macrae 1997).

MAPPING TRANSITION STRATEGIES

To clarify how the sequence of intervention targets outlined above can constitute a transition to health system strengthening, they can be plotted on two dimensions: the relative focus on service delivery versus system rehabilitation, and the extent to which implementation bypasses or partners with country governments. Figure 1 illustrates the map for the three intervention targets. Interventions whose

FIGURE 1. INTERVENTION TRANSITIONS TO SUSTAINABLE HEALTH SYSTEM DEVELOPMENT



Source: *Author, adapted from Canavan et al. (2008: 4)*

BOX 2. SEQUENCED TRANSITION FOR HEALTH SYSTEM STRENGTHENING IN TIMOR LESTE

International donors supported a transition strategy to rebuild the health system in Timor Leste. The strategy consisted of four phases, beginning with imported external capacity from international NGOs in Phase I while technical assistance helped to establish new institutions capable of managing an integrated public health system.

Phase I: During the initial emergency phase, NGOs reestablished essential services, saving lives and alleviating the suffering of a population traumatized by the recent violence. An Interim Health Authority was established in February 2000 comprising 16 senior Timorese health professionals in Dili and one in each district along with a small number of international experts. IHA staff made assessment visits to all districts in preparation of a first sectoral planning exercise.

Phase II: The health authority (now called the Department of Health Services, or DHS) started work on the establishment of a policy framework, medium-term planning for the sector and on national preventive programs, including immunization campaigns. During the second half of 2000, DHS signed Memoranda of Understanding with NGOs for each district; formalizing district health plans service standards, and initiated a basic system for distribution of essential pharmaceuticals.

Phase III: In April 2001, the Ministry of Health took over the financing of a majority of the NGOs in the districts. By the third quarter of 2001, the first round of recruitment of health staff had been completed. Most of these staff had previously worked with NGOs or on government stipends prior to finalization of the recruitment process. Several senior staff members in the department were also sent for public health management training.

Phase IV: At the request of the government, NGOs gradually withdrew from the districts between September and December 2001, and the Ministry of Health assumed management control of all health facilities. International doctors replaced departing NGO practitioners while Timorese doctors received training overseas, and five public health specialists deployed to serve as relay between the Ministry and district health centers. A new Autonomous Medical Stores and associated tracking system took over pharmaceuticals distribution. A few NGOs remained to provide specialized services on a countrywide basis.

Source: Rohland and Cliffe (2002: 12).

operational space falls largely in the lower left quadrant emphasize humanitarian and emergency health objectives. Those that fall in the upper right concentrate on sustainable health system development objectives. Transition strategies, according to this model, establish an intervention trajectory that moves from the lower left of the figure to the upper right. As the model shows, that trajectory moves interventions in the direction of increasingly engaging with government as a partner rather than bypassing state actors, and focusing more and more on service delivery as it relates to the capacity of the health system. This does not mean that system-strengthening strategies do not pay attention to delivering services, but rather that they pay increasing attention to how external assistance and resources focused on services can contribute to (or detract from) building and reinforcing the capacities needed for the health system to function effectively on a sustainable basis. Clearly, in practically all fragile, post-conflict states, external resources and expertise will be needed for an extended period.

Traditionally, international NGOs have been key actors in bypass strategies in fragile, post-conflict state interventions. Since one of the defining features of fragile states is weak or nonexistent state capacity to provide services (see Box 1), donors seeking to mobilize quick response look to alternative sources of capacity and expertise to fill the gap. For health services, prominent among these sources are NGOs (international and local), along with private sector firms or international donors themselves (see Mckechnie 2003). In some fragile states, donors – for a combination of foreign policy as well as technical reasons – are not willing to work with country governments and choose to route health sector assistance resources through NGOs and other external actors even when country public health actors possess some degree of operational capacity.

Box 2 provides an example from Timor Leste of a transition strategy that moves from bypass to partnership with an increasing emphasis on systems issues. This case illustrates how international NGOs, donors, and government officials worked together to restore the health system after the breakdown in public institutions and services.

The fact that both the United Nations Transitional Administration in Timor Leste and the World Bank gave high priority to health contributed to the success of this partnership. The donors provided financing, and they allowed Timorese professionals to take the lead. International health experts worked as partners with the Timorese to develop their skills and knowledge and to strengthen organizational systems and policies (see Conflict, Security and Development Group 2003: para. 184). The capacity of the new health system remains fragile and will require ongoing assistance to become more firmly institutionalized, but the explicit focus on the transition to a rehabilitated system has helped to put in place the foundations for sustainability.

TRANSITION CHALLENGES

The challenges facing both international donors and country partners in promoting health system rehabilitation in fragile, post-conflict states are immense. Experience in many fragile states has led to the identification of several critical issues that affect the possibilities for successful transitioning, from responding to immediate health needs to ultimately supporting health system strengthening. Frequently, these issues pose dilemmas for donors, where choices may solve one problem at the expense of creating others. The following discussion summarizes these issues.

Decisions taken early in rehabilitation efforts influence subsequent possibilities and options. The trade-offs between mobilizing external resources, including international NGOs, for dealing with immediate health needs and health-system capacity building concern what some have termed the "two-track problem," where the two tracks have fundamentally different strategies and timeframes. Bypassing the country health system and its actors, which may make sense in terms of rapid response when local capacity is weak and insufficient, often lays the groundwork for incoherent sectoral assistance as individual donors pursue their particular interests and technical emphases. Filling the operational vacuum with international NGOs and private firms contributes to a proliferation of projects and actors that exacerbate the difficulties in coordination and consistency, which are needed to move to system-wide rehabilitation. Further, NGOs and firms, because they offer attractive salaries and other benefits, often suck capacity out of the health system by luring country health professionals away from their public sector positions (Brinkerhoff 2007b). The dominance of vertical programs, which is problematic in many developing nations, is particularly strong in fragile states (see Macrae 1997). Thus, reliance on external expertise often does little to build indigenous capacity and can contribute to losing capacity as well (Brinkerhoff 2007b, Smillie 2001).

Donor procedures and funding mechanisms create roadblocks for sustainability-enhancing investments. Numerous observers have noted the negative impacts of donor programming and contracting procedures on post-conflict reconstruction (see, for example, Brinkerhoff 2007a and 2007b, OECD 2008). Reporting and accounting requirements often drive donors to NGOs and private firms because they have the financial management capacities necessary to respond to those requirements, whereas in-country organizations may not. Concerns about corruption and leakage lead donors to cloister funding in protected trust funds that bypass ministries of finance and health (see Schiavo-Campo 2003). Packaging interventions as discrete projects facilitates results-based reporting on visible impacts so that donors can demonstrate their effectiveness to their constituents. Less "glamorous" investments, such as paying health worker salaries or funding recurrent costs for local health facilities, are foregone in favor of short-term visibility. Another problem is that the sources of humanitarian versus development funds are different for most donors, which in some circumstances has created a funding gap as the humanitarian window closes before the development one opens. For example, in Liberia in 2006, it appeared that humanitarian assistance NGOs were preparing to depart prior to donors putting in place transitional funding; the gap was avoided when the Liberian government requested an extension of humanitarian funding for basic health services at a donors' conference in Washington, DC, in February 2007 (Canavan et al. 2008).

In practice, transition strategies are not sequential but iterative. Initial analyses will identify major problems to be addressed, and will contribute to a preliminary action plan. As implementation moves

forward, new knowledge will emerge, additional constraints will be identified, and revised plans put together (High-Level Forum 2005). Over time the perspectives, capacities, and commitment of country decision-makers will likely evolve, which will contribute to the iterative nature of transition planning and implementation. Some health system strengthening activities may begin early in a reconstruction effort, while service delivery may still be largely provided through international NGOs. Thus, not all aspects of the transition will proceed in linear fashion at the same pace. Two other factors influencing the composition and pace of transition planning and activities are: 1) not all parts of a country progress out of conflict at the same speed, and 2) health sector resources are rarely evenly distributed throughout a country. DR Congo is a good example (see Waldman 2006). What is possible and desirable to do in Kinshasa regarding health system strengthening is not likely to be a good fit with conditions in other parts of the country.

TRANSITIONAL PROGRAMMING: SUGGESTIONS FOR ENHANCING THE ROLE OF INTERNATIONAL NGOS IN SYSTEM STRENGTHENING

As Figure 1 illustrates, the three phases of post-conflict assistance have important areas of intervention overlap. The trick for effective transition strategies is to build activities that can serve to create a foundation for longer-term health system strengthening into relief efforts to provide immediate access to health services. Transitional programming, then, needs to take into account:

- The need for the public health system (and the state more broadly) to build legitimacy among its citizens by being seen to deliver goods and services; and
- The need to rebuild (or create) sustainable public health system capacity, including in financing, operations, and governance.

The tensions inherent in the two-track problem can be diminished when donors constructively align their relief assistance with country public health agencies to:

- Identify and capitalize on existing sources of capacity (even if very small; also, these may be at the community level, not the center) and political will as starting points for health system rehabilitation;
- Consider how relief activities can be structured not as stand-alone efforts, but as integral components of an eventual hand-off to country actors (as the case in Box 2 shows); and
- Structure service-provider contracts to create incentives for transitioning service-delivery operations from international NGOs and firms to using NGOs and firms to build local capacity and engage with public health system actors.

Table 1 offers a practical illustration of how such alignment could be achieved. It suggests a set of activities that could be included in grants/contracts with NGOs (or private firms) to increase their role and effectiveness in moving from the humanitarian relief phase of health sector intervention toward health system strengthening.

CONCLUSION

Many health professionals and policymakers agree that the main objective of any health sector intervention should be improved health outcomes. However, without attention to health system strengthening, fragile states cannot move beyond dependence upon external resources and expertise to sustain improvements in health outcomes. Sustainable service delivery capacity and efficient management systems and procedures, along with effective policy-making and health governance, are necessary for fragile states to establish sustainable development of their health sector. This brief has clarified the path of health development transitions in fragile states from emergency response to systems rehabilitation, and has offered some suggestions on how donors can enhance what health NGOs do to transition from relief to system strengthening as part of their service delivery activities.

TABLE 1. SUGGESTED CONTRACT ACTIVITIES TO SUPPORT TRANSITION FROM RELIEF TO HEALTH SYSTEM STRENGTHENING

Activity to include in NGO contract	Importance	Expected results	Statements of good health governance practice
Planning: Develop an annual plan of activities and include host-government health officials in annual planning (both at the facility and state or county levels)	• Develops planning capabilities and experience of health officials	• Better planning once system is government operated • Better resource utilization	• Ability to develop plans that respond to community needs • Planning would not have to include financial planning (proprietary information of NGOs), but activities, level of effort, etc. • **Indicators:** (1) annual plan of activities; (2) number of planning sessions where government personnel participated • **Roles for development projects:** (1) provide or facilitate development of common templates for annual planning; (2) help bridge facility and state/county planning
Information: Share information about service use and related data (equipment, capabilities of facilities, catchment populations, and demographics) with host government; provide annual results to county health authorities	• Allows government to compile and analyze aggregated data for planning and coordination	• Government will have a benchmark against which to measure post-relief service delivery • Identification of gaps in service delivery that could be filled by new initiatives (contracting, new government facilities, new services provided)	• Where there is a defined national information system, NGOs should report through it and not create parallel competing systems • **Indicators:** (1) information system reports with complete data provided to government by NGOs; (2) annual report of activities received by county health authorities • **Roles for development projects:** (1) facilitate the development of a common information system, drawing on the experience of NGOs and other countries; (2) assist with developing the skills and support capacity to analyze, publish, and use compiled data for feedback to providers and policy development
Training: Develop and implement an in-service staff training plan and include host-government health workers in the training	• Develops skills of government health workers	• Reduced need for in-service training once system is government operated • Better quality care immediately post-relief	• **Indicators:** (1) in-service training plan; (2) person weeks of in-service training provided to government health workers • **Roles for development projects:** (1) provide or facilitate development of common templates for in-service training; (2) assist with development of a comprehensive human resources development plan for government health workers that accounts for in-service training through NGOs
Basic services package: Implement at least the basic package in the services delivered	• Matches services delivered during relief phase-out to services to be offered post phase-out	• No gap in services delivered between relief and post-relief situation will give government greater legitimacy and credibility	• Where there is no defined basic packages, NGO representatives should be invited to participate in the definition of the package (covering Population, Health and Nutrition priority services) • **Indicator:** (1) reports from NGOs on services offered and used, showing match to basic package • **Role for development projects:** facilitate process of developing a basic package of services with NGO, civil society, and government participation
Supervision: Develop a supportive supervision plan, then perform supervision jointly with host-government officials	• Allows health officials to begin to be visible and to learn about how to perform effective supervision • Increases supervisory skills	• Improved post-relief supervision practices • Increased management capacity	• **Indicators:** (1) number of joint supervisions conducted; (2) number of health officials participating in supervisions • **Roles for development projects:** (1) provide or facilitate development of common template for supervision planning; (2) provide and facilitate adaptation of supportive supervision tools from other countries; (3) facilitate development of a national supportive supervision policy

Source: Marty Makinen and author.

REFERENCES

Brinkerhoff, D.W. 2007a. Introduction—Governance Challenges in Fragile States: Re-establishing Security, Rebuilding Effectiveness, and Reconstituting Legitimacy. In D.W. Brinkerhoff, ed. *Governance in Post-Conflict Societies: Rebuilding Fragile States*. London: Routledge, 1-23.

Brinkerhoff, D.W. 2007ab. Capacity Development in Fragile States. Discussion Paper No. 58D. Maastricht, The Netherlands: European Centre for Development Policy Management, May.

Brinkerhoff, D.W. and T. J. Bossert. 2008. Health Governance: Concepts, Experience, and Programming Options. Washington, DC: U.S. Agency for International Development, Health Systems 20/20, Abt Associates Inc., Policy Brief, February.

Canavan, A., P. Vergeer, J. Hughes, and N. Ezard. 2008. Health Sector Policy and Funding Gaps in Post-conflict Settings: A Question of Aid Effectiveness in Transition. Final Draft—Executive Summary. Amsterdam: Royal Tropical Institute of the Netherlands. Report for the Health and Fragile States Network.

Checchi, F., M. Gayer, R. F. Grais, and E. J. Mills. 2007. Public Health in Crisis-Affected Populations: A Practical Guide for Decision-Makers. London: Overseas Development Institute, Humanitarian Practice Network, Paper no. 61, December.

Conflict, Security and Development Group. 2003. East Timor Report. London: Kings College, February. Available at: ipi.sspp.kcl.ac.uk/rep006/index.html.

High-Level Forum on the Health MDGs. 2005. Health Service Delivery in Post-Conflict States. Paris: OECD, November 14-15.

Jones, S.G., L.H. Hilborne, C.R. Anthony, L.M. Davis, F. Girosi, C. Benard, R.M. Swanger, A. D. Garten, and A. Timilsina. 2006. *Securing Health: Lessons from Nation-Building Missions*. Santa Monica, CA: RAND.

Macrae, J. 1997. Dilemmas of Legitimacy, Sustainability and Coherence: Rehabilitating the Health Sector. In K. Kumar, ed. *Rebuilding Societies after Civil War: Critical Roles for International Assistance*. Boulder, CO: Lynne Rienner, 183-201.

Macrae, J., A. B. Zwi, and L. Gilson. 1996. A Triple Burden for Health Sector Reform: "Post"-Conflict Rehabilitation in Uganda. *Social Science and Medicine* 42(7): 1095-1108.

Mckechnie, A.J. 2003. Building Capacity in Post-Conflict Countries. Washington, DC: World Bank, Social Development Notes, Conflict Prevention and Reconstruction, No. 14, December.

OECD (Organization for Economic Cooperation and Development). 2008. Service Delivery in Fragile Situations: Key Concepts, Findings and Lessons. Paris: OECD, Development Assistance Committee Discussion Paper.

Pavignani, E. and A. Colombo. 2001. Providing Health Services in Countries Disrupted by Civil Wars: A Comparative Analysis of Mozambique and Angola 1975-2000. Geneva: World Health Organization.

Roberts, B., S. Guy, E. Sondorp, and L. Lee-Jones. 2008. A Basic Package of Health Services for Post-Conflict Countries: Implications for Sexual and Reproductive Health Services. *Reproductive Health Matters* 16(31): 57-64.

Rohland, K. and S. Cliffe. 2002. The East Timor Reconstruction Program: Successes, Problems and Tradeoffs. Conflict Prevention and Reconstruction Working Paper No. 2, Washington, DC: World Bank.

Schiavo-Campo, S. 2003. Financing and Aid Management Arrangements in Post-Conflict Situations. Washington, DC: World Bank, Social Development Department, Conflict Prevention and Reconstruction Working Paper No. 6, June.

Smillie, I. 2001. Capacity Building and the Humanitarian Enterprise. In I. Smillie, ed. *Patronage or Partnership: Local Capacity Building in Humanitarian Crises*. Bloomfield, CT: Kumarian Press, 7-25.

USAID (U.S. Agency for International Development) 2005. Fragile States Strategy. Washington, DC: USAID, Document No. PD-ACA-999, January.

Vaux, T. and E. Visman. 2005. Service Delivery in Countries Emerging from Conflict. Final Report. Bradford, UK: University of Bradford, Department of Peace Studies. Report for Department for International Development, January.

Waldman, R. 2006. Health in Fragile States. Country Case Study: Democratic Republic of Congo. Arlington, VA: Basic Support for Institutionalizing Child Survival. Report for USAID, June.

Waters, H., B. Garrett, and G. Burnham. 2007. Rehabilitating Health Systems in Post-Conflict Situations. Helsinki, Finland: United Nations University, World Institute for Development Economics Research, Paper No. 2007/06, January.

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