Fragile states and aid effectiveness: an expanded bibliography

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Overview

The literature reviewed here looks at why donors should invest in fragile states. The authors point to the significance of aid in contributing to stabilisation, peace and recovery; the cost of conflict; and the value of restoring governance and the legitimacy of state. Some authors highlight the links between aid and state building and health system reconstruction.

Most of the health-focused literature reviewed here suggests that visible and effective provision of basic services is a necessary response to the high morbidity and mortality marking conflict-affected and transitional states, but also has the potential to build the legitimacy of the state. Some authors argue that well-designed service delivery can help to build state capacity, through collaboration with NGOs and technical support and resources from donors.

There is a wealth of more general literature on service delivery in fragile or post-conflict contexts, and approaches to health system reconstruction based on lessons learned. On the other hand, there is limited literature on aid flow and on the inter-relationship between health sector development and aid effectiveness. Meanwhile, the importance of alignment, harmonisation and aid predictability is a feature of the humanitarian reform literature, World Bank reviews and selected ODI papers.

Because of the wide range of definitions for ‘fragile state’ used in the literature – based on World Bank CPIA criteria but modified according to the strategic interests of donors – we have provide a table of fragile state definitions used by various donors in the annex of this document.
Definitions of ‘fragile state’
1. Matrix of ‘fragile state’ definitions by donor (see Annex 1)
2. OECD DAC website – Fragile state group (www.oecd.org/dac/fragilestates)

Fragile states are generally defined by multilateral and bilateral donors based on a series of economic, good governance (willingness and capacity) and socio-political criteria. In order to elaborate on the respective definitions, we have provided a matrix of the major donor definitions and country selection in Annex 1.

Fragile states and transitions: general

1. Links fragile states to different definitions. Describes fragility factors of maturity of independence, size of government, leadership and conflict. Highlights need for political willingness and development capacity to ensure aid effectiveness. Looks at relationship donors and different fragile states and their symbiotic relation - Burma (lack political will and capacity), Rwanda (donor complicity in state collapse), and Zambia (bilaterally-assisted economic mismanagement). Makes suggestions as to how donors can influence political willingness and improve capacity.


2. The interactive influences of nation building and health system reconstruction are explored and the mutually reinforcing impact. Study attends to the degrees of coordination and planning plus infrastructure and resources available to governments post-conflict.


3. Dunne studies Rwanda and Mozambique and the role of international agencies after the conflict. He notes the importance of rehabilitation and reconstruction in the process of transition to peace as a means of preventing recurring conflict. Highlighting the need for policies of post conflict reconstruction to be context specific and taking into consideration the conflict. He illustrates the response of the international community by looking at the ODA share as part of the Gross National Income (GNI), in comparison with other low income countries in general.


4. Argues rehabilitation needs to go beyond reconstruction and tackle root causes of instability. Looks at Uganda, Cambodia and Ethiopia and how aid can fuel tension. It raises dilemmas in transition period - legitimacy of the incoming government and the organisation of the aid system which needs to change as development aid requires a strong government.
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<th>Author/Title</th>
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<tr>
<td><strong>Fragile states and health systems</strong></td>
<td>1. Definitions of fragility should not be fixed but contextualised. Health as a peace dividend is discussed and concludes that short-term high impact interventions are critical in post-conflict situations for cementing the population’s trust in the government and conferring legitimacy. Quick impact is a pre-requisite for recovery. Waldman raises questions about bypassing the country government to achieve efficiency gains in service provision, or engaging the state to support fledgling governments. He argues that visible health provision such as permanent clinics and hospitals (as opposed to purely humanitarian health support) are powerful means of convincing people of the legitimacy of the state.</td>
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<tr>
<td>1. Waldman, R. (2007). Health programming in post-conflict FS. (BASICS) – A briefing paper.</td>
<td>2. Describes well the tension between the extensive needs and the funds that may be available in fragile states versus the absorptive capacity. It highlights some of the major issues, also problems from donor side. Taylor provides a good summary table on different donor approaches working in health systems (p.17) / link with Colenso and Leader (Aid instruments in fragile states) – who delineate the mix and sequencing of aid instruments in fragile states.</td>
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<td>2. Taylor. L. (2005) Absorptive capacity of health systems. (HLSP/DFID Paper).</td>
<td>3. This paper provides an overview of characteristics of a fragile state (what is it – based on criteria for legitimacy and effectiveness in providing basic services to the population (page 12 for full review). Planning for recovery should include: allocation, production, distribution and financing. He addresses why health is a priority in fragile states and what the likely impact will be on: equity, infrastructure, access and capacity building.</td>
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<td>3. Newbrander. W. (2007). Rebuilding health systems and providing health services. (Management Sciences for Health Occasional paper No 7).</td>
<td>4. Links relief to rehabilitation and development. Argues for need to address immediate health needs, restoring a package of essential health services as soon as possible while at the same time rehabilitating the health system. A framework is provided (p.6) to analyse inputs (finance, HR, physical infrastructure, information systems, essential drugs) and policies for post-conflict health system rehabilitation (donor coordination, government political commitment, partnership with NGOs, prioritisation, planning and integration of health services, long-term sustainability of the approach).</td>
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<td>5. Waldman, R. (2006). Rebuilding health services after conflict: lessons from east Timor and Afghanistan.</td>
<td>5. Focuses on transition from relief to development and compares East Timor district health plans, SWAp approach and donor coordination to Afghanistan's program approach (e.g. contracting). Highlights difficulties in transition: donors deal with emergency or development funding in separate units and there are no minimum standards for post-conflict interventions. He questions whether humanitarian NGOs are appropriate to address transitions.</td>
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<td>6. Sondorp, E et al (2007). Promoting health equity in Fragile States. WHO Health systems knowledge network by Conflict and health unit.</td>
<td>6. The paper explores what the main factors are that threaten health equity and health care equity in conflict and post-conflict fragile states; which strategies can reduce the impact of these factors and what the roles are of the different actors involved; and how we can address equities (requires robust Health Management Information systems (HMIS) to produce useful data and tracking of health access/coverage).</td>
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<td>7. Mac Rae. J. (2000). Aiding recovery; role and function of international assistance in Cambodia, Uganda and Ethiopia (MacRae – PhD Thesis)</td>
<td>7. In-depth analysis of recovery and transition issues that impact on health sector reconstruction with some examples from fragile states. Linked with other co-authored paper on health system reconstruction (Uganda, Cambodia) referenced in this review.</td>
</tr>
<tr>
<td>8. Mac Rae, J. (1996). Triple burden for the health sector: post conflict rehabilitation. ODI HPG paper.</td>
<td>8. Describes the double burden of unaffordable health system pre-conflict combined with the effects of the conflict, and how policies to rebuild health services can be an extra burden if not planned properly. Notes issues influencing this at Uganda level.</td>
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<tr>
<td>9. Lanjouw, S. MacRae, J. Zwi, A. (1999) Rehahilitating health services in Cambodia; the challenge of rehabilitation in chronic political emergencies. Health Policy and Planning 14(3); 229-242.</td>
<td>9. Retrospective on the evolution of health sector policy and planning leading to implementation in Cambodia (1991 – 1999). (i) Post-conflict countries rely on aid as a major source for rehabilitation efforts (ii) coordinating efforts lies at the heart of the reconstruction and systems recovery (iii) information, framework and management/directive coordination are all essential mechanisms for recovery phase (iv) project cycles that are not commensurate with needs, donor policies of engagement/alignment are critical to the opportunity for success and or failure if not implemented appropriately.</td>
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<tr>
<td>10. Stuer. F. (1998). Enhancing health program efficiency in Cambodia; a case study. Cambodia Urban Health Care Association.</td>
<td>10. Provision of health services adopting a public/private mix with emphasis on approaches that can be adopted in fragile state contexts to alleviate the burden on the public health sector. (Not directly relevant to fragile states but useful approach for reconstruction of health systems and efficiency enhancement).</td>
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<td>12. Bornemisza, O. Sondorp. E. (2002). Health Policy formulation in complex Political Emergencies and post conflict countries- A lit review. (LSHTM paper).</td>
<td>12. Health policy formulation in post-conflict countries has been successful in providing direction to health service providers and channelling donor resources more effectively. However, in complex political emergencies the situation is complicated by the fact that there is no legitimate government to take control. Requires strong donor support and need to be inclusive and collaborative. Provides recommendations from Bower’s Afghanistan study and need for more research.</td>
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## UN humanitarian reform & aid effectiveness


   Comprehensive review of the Common Humanitarian Fund (CHF) as an example of a variant of pooled funding mechanisms – explores the pros and cons of deploying this aid instrument and approach in transition contexts (piloted in DRC and Sudan). Overall, encouraging review and suggests that CHF has potential to contribute towards improved harmonisation of transitional agencies.


   Full-scale review of the UN cluster approach for all sectors. Attention paid to the functioning of the health cluster highlights many strengths and weaknesses with respect to coordination, alignment, predictability of funding and needs assessment.


   Findings from review of OCHA-managed ERF in five countries, including DRC and Liberia. Explains ERF aim to provide funds quickly, mainly to NGOs to deal with unforeseen humanitarian needs. Finding that disbursements have been slow, sometimes too narrowly defined and procedures too constraining. Found most useful for addressing ongoing needs in emergency situations; little evidence they link to recovery programs as more short-term one-off projects. Little support given to local NGOs and no exit-strategy.


   Central Emergency Revolving Fund (CERF) established by UNGA in 1991, funded by donor contributions and used to fund emergencies for operational organisations and entities of UN. Rapid disbursement of funds and light disbursement make it effective. OCHA is the steward of the funds. Recommend expansion to a grant-making E-CERF for rapid response, equity and standby capacity. This would overcome reluctance of agencies to apply for CERF loans without assured donor funding and allow to be used for funding of neglected crises. Requires UNGA approval.


   Describes the importance of good humanitarian donorship and that achieving its potential requires high-level commitment. There is a need for a collective performance framework as well as individual performance and accountability requirements of donors. Obstacles mentioned include limitations of the M&E system to assess effectiveness and impact, as well as donors’ organisational structure, operational procedures and policies that do not facilitate harmonisation.


   Focuses on the key principles of good humanitarian donorship and what is lacking across a range of donors – call for more coherent aid instruments to be adopted by all donors.
### Aid financing mechanisms in post-conflict countries


   Summarises research on aid allocation and effectiveness, highlighting OECD DAC research findings on aid allocation to fragile states. Often under-aided but more important is the volatility of aid - reasons not obvious and exacerbated by non-transparent and inconsistent allocation criteria of donors, leading to unpredictable aid flows. Highlights donor coordination problem, absorptive capacity, need to learn more which aid modalities work well in fragile states and how to sequence.


   Thix paper explores how aid impacts on a range of human development indicators. The authors argue that most aid effectiveness indicators focus on per capita gains and should focus on asset-based gains. They explore why it is so difficult to measure the effects of aid. Sanitation, education, health and fertility are measured. Health includes infant and child mortality rates and life expectancy. Positive correlations are demonstrated between development indicators and aid invested per country.


   Describes World Bank lessons learnt for post-conflict countries, using case studies of Gaza, Bosnia, East Timor, Kosovo, Sierra Leone, Great Lakes and Afghanistan. It argues further that the World Bank is best-placed for effective and timely (!) assistance in post-conflict reconstruction, ensuring involvement of recipient government and local partners and other donors. Interesting are its lessons learnt on Multi donor trust fund and the potential competition between the aid management agency - initially set up to compensate local capacity - and government structures. Also emphasises the need for an exit strategy. Highlights some organisational issues such as the issue of protracted delays for funds to be deposited before starting and the need for some unallocated funds to deal with emergencies.


   This paper reviews the current financing mechanisms and their respective merits: it provides a critical analysis of humanitarian aid flows and the issues of targeting aid, determinants of aid effectiveness in crisis/post-crisis and donor preference for aid instruments use. They argue that the multilayered nature of the business makes it extremely difficult to gauge overall aid effectiveness, and question overall accountability, efficiency and effectiveness in this widely heterogeneous context. This raises major concerns over mandate protection, sovereignty, independence and inclusiveness. The donor and UN reforms may have improved components of the system but the overall aid architecture is still inherently inefficient. (analysis of the pros and cons of CERF, CAP, CHF)


   Leader and Colenso identify the current mix of aid instruments and aid frameworks that are employed in fragile states. It offers a working typology of aid frameworks and aid instruments: and also present an illustration of frameworks and instruments that are appropriate to conflict, reconstruction and development.
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<th>Author/Title</th>
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<tr>
<td>6. MSc Thesis/LSHTM. (2007). Global Fund – does the GFATM model of engagement hold the answer? Submission for MSc thesis/candidate No P3168.</td>
<td>6. The challenges of delivering large GF grants where no or limited capacity exist - Allocation of GFATM Funds to fragile states is significant (US$1.1b x 2 years for 123 grants in 45 fragile states). (i) Can GF be a viable instrument for provision and promotion of essential health services (ii) does it address equity concerns and how public private partnership impacts on fragile states health systems: this is the major enquiry of this dissertation paper.</td>
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<td>7. GAVI (2007). Improving GAVI’s engagement and effectiveness in fragile states. http/ <a href="http://www.gavi.org">www.gavi.org</a></td>
<td>7. This summary paper indicates that GAVI procedures are more suited for stable countries but support many fragile states. Review team has looked at GAVI’s past experiences in fragile states (see box p.9) identifying problems. Recommends classification fragile states to be used (box definitions used by others, p.14) to subsequently develop appropriate policies. Researchers also checked GAVI website (<a href="http://www">www</a>. Gavi.org) for info on health system strengthening but nothing specific on fragile states though, just the normal HSS and indeed some fragile states will receive funding.</td>
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<td>8. Global Fund (2006). Paper on investments in fragile states: early results. (Global Fund Geneva) <a href="http://www.globalfund.org/fragilestates">www.globalfund.org/fragilestates</a></td>
<td>8. One third of committed funds is in fragile states. Comparative analysis of performance highlights all those to fragile states performed well and are comparable to stable state performance. Most were managed by Principal Recipients from govt sector. A proactive Country Coordinating Mechanism seems to make difference. Concludes that investment in fragile states is feasible and that its performance based funding model may in fact build capacity as grants are implemented with input from technical partners.</td>
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<td>10. OECD DAC (2006). Aid harmonisation and alignment; bridging the gaps between reality and Paris reform agenda. <a href="http://www.oecd.org/parisdec">www.oecd.org/parisdec</a></td>
<td>10. This paper brings to the fore some of the problems, namely that “four additional policy measures are identified which cannot be managed easily within the Paris agenda: better international balancing of aid allocations; new instruments with longer commitment horizons; liquidity arrangements to enable ‘scaling up’ across several countries; and independent aid rating institutions linked to market-like sanctions.”</td>
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<td>11. Mc Gillvary, M. (2007) Analysis of deviations and delays in aid disbursements (UNU WIDER discussion paper)</td>
<td>11. Highlights that there is a paucity of research and empirical findings regarding the effect of aid and causes of uncertainty across a range of recipient countries and donors. Causes can be recipient based or donor based or both – this study is focused on donor policy and behavior in the context of FS and causes of delays in disbursement. Aid commitment has exhibited a positive trend over the decades: donor per capita commitments have increased but delays in disbursement manifest across 22 OECD member donor states.</td>
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<td>Capobianco, E.</td>
<td>(2007). A Review of Health Sector Aid Financing to Somalia (2000-2006) (World Bank, Washington)</td>
<td>Objective of study: (i) To assess levels of donor financing (all international contributions to Somalia health sector) throughout the six years from 2000-06. (ii) To understand which health interventions were prioritized by policy planners and to evaluate how evenly the aid was distributed by different zones in Somalia (South/Central, Somaliland and Puntland). Excellent and perhaps the only full scale analysis of aid trends to the health sector in fragile state contexts.</td>
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<tr>
<td>World Bank LICUS</td>
<td>(2006). Engaging FS – Independent Evaluation Group. Review of WB support to LICUS countries</td>
<td>Provides WB FS typology for engagement in FS, and challenges, characteristics and pre-requisites for working effectively in post-conflict countries. The paper explores the necessary organizational set up that is required to be effective in FS contexts and explores the internal institutional strengthening is required within World Bank and LICUS to deliver effective programs.</td>
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<td>ODI/HPG</td>
<td>(2006). Beyond the continuum; donor policy and aid effectiveness review (ODI, HPG paper) (<a href="http://www.odi/rg.org">www.odi/rg.org</a>)</td>
<td>Describes move from relief-development continuum seen as managerial issue to political. Highlights move to add security following 9/11- human security leading to more aid to protracted crisis. Brings some tensions between relief and development in FS to the fore.</td>
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<td>World Bank</td>
<td>(March 2007). Strengthening WBs Rapid Response and long term engagement in Fragile States (Operations Policy &amp; Country Services Fragile States group paper)</td>
<td>The paper focuses on WB capacity and support to fragile states based on lessons learned from previous interventions in East Timor and Cambodia. Prioritization of speed and long term engagement is highlighted as well as high level of skill and knowledge of advisors and policy makers with ability to provide analytical appraisals of country contexts.</td>
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<td>Author/Title</td>
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| **Liberia** | 1. Highlights some of the funding gap issues occurring in Liberia (see review for details): They argue that the end of political transition does not coincide with transition relief – development but funding does. The focus on humanitarian assistance without much consideration for sustainable reconstruction for the health sector and its underlying financial resource problem has created significant problems. In addition, human resources problems and limited foresight planning in regards to withdrawal of humanitarian agencies that currently provide services in about 200 clinics is expected to create problems. There is little insight in government expenditure in health but the main funding for the health sector is humanitarian funding ($20M in 2005) or from Global Fund ($10M) which is anticipated to be withdrawn without insight into potential replacement through development funding. It will take years for Liberia to be able to come up with these resources itself and thus there will be a significant health financing gap. For that reason, it is argued that the health sector requires an additional transitional period of at least three to five years with funding and ways of combining health service delivery (contracting is an option) with sustainable health sector reconstruction.  

2. Describes the findings of a follow up visit in 2006. Positive development is the draft health policy and plan developed by the Ministry of Health & Social Welfare of Liberia. However, unclear remains how these would be funded as humanitarian actors intend to pull out while development actors have not (yet) committed funding. Cost estimates for recurrent costs of basic health package delivery are made in the report and estimated at $15M for Liberia, based on a population of 3.2M.  

Even though this amount is available for Liberia, it is not earmarked for this but rather is provided through projects, fragmented primary health service delivery, vertical interventions and uncoordinated technical support. In addition, funds are needed for reconstruction and capacity building and training to enable longer term health sector reconstruction. The Liberia Partner’s Conference minutes annexed to the report, state that $12-18 per capita, or 50-75M per year will be needed to rebuild the health sector, based on experiences in other post conflict countries. A major surprise seems to be the lack of donor commitment and donor coordination, the latter also within donors- between emergency and development funding, and harmonisation. |

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1 It does not seem clear which countries this is based on, for what period, etc.

Fragile states/post conflict and state building


5. This paper is more focused on state building & the factors which contribute to more effective management and coordination of peace building and reconstruction efforts. The paper outlines the five main principles of aid effectiveness; Ownership, Harmonization, Alignment, Results, and Mutual Accountability. DCD/DAC/EFF. Paris: Organization for Economic Cooperation and Development

2. State building in post conflict requires better understanding causes of fragility, often due to weakness in political process to meet citizens expectation versus state capacity to deliver services due to incapacity, elite behaviour and crisis of legitimacy. First priority is governance structures which address inequity and inefficiency and promotes accountability. The new Integrated Peace building Strategy process at UN, supported by WB, may be most appropriate. If state leadership is credible, advocates for joint multi-donor strategy with donor and direct budget support. If no or weak social contract then donors need political engagement with government and service delivery support or substitution. Notes importance of donor coordination.

3. This paper explores the entry points and approaches to work with fragile states and studies donor behaviour based on 2 key parameters (1) legitimacy and (2) effectiveness of the recipient government. Advocates for engagement beyond the state, with private sector, civil society and nonstate groups (useful matrix based on the typology and points of entry). Useul matrix provided based on legitimacy and institutional capacity.

4. Interesting contributions of different authors on rebuilding governance, utilising case studies. Highlights three strategies to rebuild governance; reconstitute legitimacy, re-establish security and rebuild effectiveness.

5. Focus on peace building in the context of Sierra Leone and entry points from health sector towards maintaining stability and recidivism of inter-ethnic conflict through overcoming of inequities in health service delivery.
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<td><strong>Assessment tools adopted by donors/bilateral and humanitarian reform agencies</strong></td>
<td>1. Paper adopts a framework perspective as it promotes the use of analytical frameworks according to which donors can subsequently allocate resources in a consistent, transparent and evidence based manner. However, its main focus is on choices of allocation between different crisis and the extent of funding. Provides quick overview of ways in which resources can be allocated and its advantages and disadvantages. It suggests joint frameworks and coordination mechanisms would be beneficial to improve the effectiveness of the combined response, looks at existing donor criteria and recognises it is unlikely there will be a one-size fits all solution for different donors but highlights the importance of greater clarity on how particular donors allocate and how they intend to allocate according to need.</td>
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<td>3. World Bank (2006). Transitional Results Matrix; Using results based frameworks in fragile states. UN Development Group. World Bank.</td>
<td>3. TRM is currently used in post-conflict countries to develop a priority strategic plan jointly with transitional/legitimate governments – example from East Timor on its use (see review)</td>
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<td>5. Meeting Note: Seminar on Integrated Peace building Strategies (IPA, CID, 2007)</td>
<td>5. Describes complexity of transition from conflict to peace and proliferation of tools for coordination, funding and planning. Highlights that UN's new Integrated mission planning process (IMPP) is to look at different stages, incl. 'review and transition planning. System still needs to be implemented. Notes the role of the UN peace building commission to advocate for continued support to minimize aid gaps.</td>
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### Conference proceedings


   Highlights fragile states receive less aid per capita (40%) than other low income countries, that aid is more volatile, more fragmented and more poorly coordinated. Carries high risk for donor and is costly but needed from MDG perspective. Importance of context and dual approach to address basic health needs and build more lasting institutions. Alignment necessary but difficult to achieve, shadow alignment important. Use of Transitional Result Matrix for planning, importance of predictable funding, and the humanitarian-funding dichotomy. Highlights need to look at experience to reduce ‘gap’ between humanitarian and dev interventions.


   Describes need to understand changing context. Mentions challenges in transition from peace to conflict for health sector: lack funds, weak donor support, inadequate capacity, conflicting priorities stakeholders and too ambitious investment plans. Best practice of advanced planning, analyzing health service delivery developed during conflict to be integrated in health system post conflict, need to deal with distortions of focus on tertiary care and bloated workforce, rationalized drug management and shadow aligning as much as possible. Mentions some common mistakes. Guidelines for donors in post-conflict health recovery—not undermine local capacity and leadership, guaranteed funding for 10-15 years and not just political, effective and efficient coordination mechanisms. Mentions the need to discard traditional split between humanitarian and development funding in favour of flexible instruments to support complete recovery process, need to make some funds available to be managed locally to respond to needs or opportunities and provide un-earmarked funds as well.

3. **MERLIN/ London School of Health and Tropical Medicine. Health service delivery in fragile states for US$5 per person per year: myth or reality? Conference held in London, 24-25 October 2007**

   Health Service Delivery in Fragile States (focuses on post-conflict countries) – US$5 per day: Myth or reality? (Conference proceedings – LSHTM/MERLIN – October 2007). This conference assembled a wide range of policy, research and practice stakeholders to debate the pros and cons of the various approaches to health service delivery in post-conflict states. See conference proceedings for full details: www.merlin.org.uk
### Annex 1: Definitions of ‘fragile state’

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<th>Donor</th>
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| AUSAID      | Fragile states are countries that face particularly grave poverty and development challenges and are at high risk of further decline - or even failure. Government and state structures lack the capacity (or, in some cases, the political will) to provide public safety and security, good governance and economic growth for their citizens. | • instability or open conflict  
• weak administrative systems vulnerable to corruption  
• small size and geographical isolation  
• under-development - widespread poverty, lack of infrastructure and a relatively unskilled workforce. | 32 partner countries, no or little focus on Africa and Latin America. Fragile States Initiative focus on Papua New Guinea, Solomon Islands, East Timor, Vanuatu, Fiji, Nauru(+ other) post-conflict areas: Lebanon, Indonesia, Philippines, Sri Lanka |
| DFID        | States where the government cannot or will not deliver core functions to its people. (working definition) Weak institutions are the central driver of state fragility. Each instance of fragility is unique. Power selection mechanisms, control on a state’s executive, and public participation in political processes are the three main components that explain institutional weakness. | • Economic development  
is not a prerequisite for preventing fragility, but a lack of growth will mean that institution building is more difficult than otherwise  
• Natural resources; ethnic composition and a colonial heritage  
the political manipulation of these factors that can impact on state stability  
• Violent conflicts  
reduce levels of GDP, increase strain on political institutions and social tensions  
• Transitions  
frustrated expectations amongst a population previously accustomed to higher levels of service delivery or more opportunity for political participation  
• External shocks  
• Geography, climate and disease  
• The international system | Countries appear in the bottom two-fifths of the CPIA* ratings at least once between 1998-2003.  
1. Cambodia  
2. Chad  
3. Djibouti  
4. Guinea  
5. Kiribati  
6. Mauritania  
7. Papua New Guinea  
8. Republic of Congo  
9. Sao Tome and Principe  
10. Sierra Leone  
11. Tajikistan  
12. Gambia  
13. Tonga  
14. Uzbekistan  
15. Vanuatu  
16. Angola  
17. Burundi  
18. Central African Republic  
19. Comoros  
20. Côte d’Ivoire  
21. Democratic Rep of Congo  
22. Eritrea  
23. Guinea-Bissau  
24. Haiti |
DGIS
http://www.minbuza.nl

- States are the least likely to achieve the Millennium Development Goals
- The countries in these regions are in a post-conflict, transitional phase. They all need an international peace force to guarantee stability in the region, which is a prerequisite for sustainable development.
- Fragile states can be a global threat. Terrorism, refugees, migration flows and drug-related crime can all too easily affect other countries.

- conflict-prone states
- great differences in power
- unequal distribution of security
- local instability
- state failure

Countries are asterisked as follows:
* countries that also have an actual or potential security problem
** agreement reached on phasing out of framework treaty resources
*** only humanitarian relief in response to current security situation

DGIS currently supports 36 partner countries.
1. Afghanistan
2. Albania
3. Armenia
4. Bangladesh*
5. Benin
6. Bolivia*
7. Bosnia-Herzegovina
8. Burkina Faso
9. Cape Verde
10. Colombia
11. Egypt*
12. Eritrea
13. Ethiopia*
14. Georgia*
15. Ghana
16. Guatemala
17. Indonesia
18. Kenya
19. Macedonia
20. Mali
21. Moldova
22. Mongolia
23. Mozambique
24. Nicaragua
25. Pakistan
26. Palesatine areas
27. Rwanda*
28. Senegal
29. South Africa
30. Sri Lanka***
31. Suriname**
32. Tanzania
33. Uganda*
34. Vietnam
35. Yemen*
36. Zambia

In addition, funds are provided to Sudan, Burundi, DRC and Kosovo but not through a traditional development partnership.

DGIS is currently moving towards basing their funding decisions and choices for support on country profiles which are related to i) MDG achievement ii) security and development and iii) broad-based relationships. The main criterion for the security and development profile is 'fragility or major inequality blocking poverty reduction'. The countries DGIS considers to fit this profile can be found in the right hand column.

| EC | http://ec.europa.eu | Fragile state is not commonly used in EC terminology. EC uses post-conflict areas; Cotonou agreement is guideline | Uses the ACP and OCT country list (Africa, Caribbean and Pacific/ Overseas Countries and Territories) |

3. Countries with improving aid levels
Cambodia
Chad
Eritrea
Gambia
Guinea Bissau
Niger
Sierra Leone
Tajikistan

<table>
<thead>
<tr>
<th>UNDP</th>
<th>LICUS (Low Income Countries Under Stress)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Afghanistan
2. Angola
3. Azerbaijan
4. Burma
5. Burundi
6. Cambodia
7. Cameroon
8. Central African Rep
9. Chad
10. Comoros
11. Congo, Dem. Rep
12. Congo, Rep. of
13. Djibouti
14. Dominica
15. Eritrea
16. Ethiopia
17. Gambia
18. Georgia
19. Guinea
20. Guinea Bissau
21. Guyana
22. Haiti
23. Indonesia
24. Ivory Coast
25. Kenya
26. Kiribati
27. Lao PDR
28. Liberia
29. Mali
30. Nepal
31. Niger
32. Nigeria
33. Papua New Guinea
<table>
<thead>
<tr>
<th>UNICEF</th>
<th>States that are not in conflict, sometimes have weak institutions and high levels of corruption, political instability and weak rule of law.</th>
<th>Active in 190 countries, no specific fragile state list</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>&quot;Fragile states&quot; refers broadly to a range of failing, failed, and recovering states. Fragile states differ from those that are stable and able to pursue long-term development. Fragile states rarely follow a predictable path of failure and recovery. Weak, ineffective and illegitimate governance is at the heart of fragility. Ignoring these states can pose great risks and increase the likelihood of terrorism taking root. At least a third of the world’s population now lives in areas that are unstable or fragile. USAID is using vulnerable to refer to those states unable or unwilling to adequately assure the provision of security and basic services to significant portions of their populations and where the legitimacy of the government is in question. This includes states that are failing or recovering from crisis.</td>
<td>96 countries no specific fragile states</td>
</tr>
</tbody>
</table>

The Fragility Framework: Legitimacy and effectiveness are most affected by perceptions of governance in the security, political, economic, and social domains. The criteria of effectiveness and legitimacy and their relation to these four areas are presented in a "Fragility Framework". Of particular concern is anticipating and ameliorating economic instability, food insecurity, and violent conflict, all of which are usually symptoms of the failure of governance in fragile states. Data show a strong correlation between state fragility and inequitable treatment of women.
USAID is using crisis to refer to those states where the central government does not exert effective control over its own territory or is unable or unwilling to assure the provision of vital services to significant parts of its territory, where legitimacy of the government is weak or nonexistent, and where violent conflict is a reality or a great risk.

World Bank

Fragile states are referred to as LICUS (Low Income Countries Under Stress) by the World Bank.

Low-income countries scoring 3.2 and below on the Country Policy and Institutional Assessment (CPIA), which is the primary tool used to assess the quality of country policies and the main input to IDA’s Performance-Based Allocation (PBA) system.

1. Afghanistan
2. Angola
3. Burundi
4. Cambodia
5. Central African Republic
6. Chad
7. Democratic Republic of Congo
8. Republic of Congo
9. Comoros
10. Cote d’Ivoire
11. Djibouti
12. Eritrea
13. The Gambia
14. Guinea
15. Guinea-Bissau
16. Haiti
17. Lao PDR
18. Liberia
19. Mauritania
20. Myanmar
21. Nigeria
22. Papua New Guinea
23. Sao Tome and Principe
24. Sierra Leone
25. Solomon Islands
26. Somalia
27. Sudan
28. Timor-Leste
29. Togo
30. Tonga
31. Vanuatu
32. Uzbekistan
33. Zimbabwe
34. Kosovo
20