Royal Tropical Institute

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.

Author/Title	Brief abstract of key findings
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. Brown, S. (2007). Aid to FS – do donors help or hinder? (UNU Wider paper)	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. Jones, S. (2006) Securing health; lessons from nation building in fragile states. RAND, Centre for Domestic and International Health Security.	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, J.P., "After the slaughter: reconstructing Mozambique and Rwanda" in *The Economics of Peace and Security Journal*, 2006, vol. 1 (2)	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. Mac Rae, J. (1995) Dilemmas of 'Post'-conflict Transition: Lessons from the health sector. ODI Network paper No 12.	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.

Author/Title	Brief abstract of key findings
Fragile states and health systems	
1. Waldman, R. (2007). Health programming in post-conflict FS. (BASICS) – A briefing paper.	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.
2. Taylor. L. (2005) Absorptive capacity of health systems. (HLSP/DFID Paper).	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.
3. Newbrander. W. (2007). Rebuilding health systems and providing health services. (Management Sciences for Health Occasional paper No 7).	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.
4. Waters, Garett, Burnham. (2007). Rehabilitating health systems in post conflict situations. (UNU WIDER paper)	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).

Author/Title	Brief abstract of key findings
5. Waldman, R. (2006). Rebuilding health services after conflict: lessons from east Timor and Afghanistan.	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.
6. Sondorp, E et al (2007). Promoting health equity in Fragile States. WHO Health systems knowledge network by Conflict and health unit.	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).
7. Mac Rae. J. (2000). Aiding recovery; role and function of international assistance in Cambodia, Uganda and Ethiopia (MacRae – PhD Thesis)	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.
8. Mac Rae, J. (1996). Triple burden for the health sector: post conflict rehabilitation. ODI HPG paper.	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.
9. Lanjouw, S. MacRae, J. Zwi, A. (1999) Rehabilitating health services in Cambodia; the challenge of rehabilitation in chronic political emergencies. Health Policy and Planning 14(3); 229-242.	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.
10. Stuer. F. (1998). Enhancing health program efficiency in Cambodia; a case study. Cambodia Urban Health Care Association.	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).

Author/Title	Brief abstract of key findings
11. Pavignini, E. & Colombo, S. (2001) Providing health servcies to countries disrupted by civil wars – a comparative analysis of Mozambique & Angola.	11. Analytical overview and useful retrospective on lessons learned from the health sector. (For full details, see: *Analysing Disrupted Health Systems* www.who.int/hac.org)
12. Bornemisza, O. Sondorp. E. (2002). Health Policy formulation in complex Political Emergencies and post conflict countries- A lit review. (LSHTM paper).	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.
13. Shuey, F. et al (2003). Planning for health sector reform in post conflict situations: Kosovo 1999-2000 – Shuey, Qosaj, schouten, Zwi- Health Policy V. 63	13. Analyses WHO-led efforts to develop a policy framework for emergency rehabilitation effort leading to smoother longer-term health sector development and reform. States it was too early to evaluate whether WHO was successful in this.
14. Tulloch. J. et al. (2003). Initial steps in rebuilding the health sector in East Timor. National Academic Press DC 2003.	14. Describes that Interim Health Authority and joint donor mission developed framework for SWAp of health sector and the constraints to overcome its implementation.
15. Sondorp. E. (2006). A time-series analysis of health service delivery in Afghanistan. (DFID Case Study).	15. Informative analysis of Afghanistan history: reviews health service delivery in the past and post-conflict. Too early to draw conclusions on the latter. (this paper augments the previous publication by Strong, L,. Wali, A. and Sondorp, E (2005), Health Policy in Afghanistan; 2 years of rapid change. A review of the process from 2001-2003. A study supported by EC Poverty Reduction Effectiveness Program.

Author/Title	Brief abstract of key findings
UN humanitarian reform & aid effectiveness	
1. Stoddard, A. et al (2006).Common Fund for humanitarian action in Sudan and DR Congo; Center on International Cooperation, New York University in collaboration with HPG ODI.	1. 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.
2. Stoddard, A. et al (2007). UN Cluster Evaluation. Commissioned by IASC Geneva.	2. 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.
3. Mowjee, T. (2006). Review of OCHA Emergency Response Funds. Development Initiatives.	3. 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.
4. Willits-King, B. (2005). Study on Revised CERF Mechanisms- Report for Dev Cooperation Ireland and the UK DFID.	4. 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.
5. Graves, S. & Wheeler, V. (2006). Good Humanitarian Donorship: overcoming obstacles to improved collective donor performance- (HPG ODI discussion paper)	5. 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.
6. Stoddard, A. Harmer, A. (2006). Good humanitarian donor ship; review of domestic strategies. ODI HPG paper.	6. 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.

Author/Title	Brief abstract of key findings
Aid financing mechanisms in post-conflict countries	
1. McGillvary, M. (2006). Aid allocation and fragile states. UNU WIDER discussion paper for Senior level forum on development effectiveness in fragile states.	1. 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.
2. Fielding, D. McGillvary. M. Torres, S. (2006). A Wider Approach to Aid Effectiveness: Correlated Impacts on Health, Wealth, and Fertility & Education. UNU Wider paper No 2006/23.	2. 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 morality rates and life expectancy. Positive correlations are demonstrated between development indicators and aid invested per country.
3. Shiavo – Campo. (2005). Financing and Aid Management Arrangements in Post-Conflict Situations. (World Bank paper)	3. 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.
4. Walker, P. Pepper, K. (2007). Follow the money: review and analysis of state humanitarian funding. (Feinstein International Centre/Tufts University; paper presented at GHD meeting, Geneva, July 2007)	4. 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)
5. Leader, N. Colenso, P. (2005). Aid Instruments in Fragile states. PRDE working paper 5. DFID.	5. 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.

Author/Title	Brief abstract of key findings
6. MSc Thesis/LSHTM. (2007). Global Fund – does the GFATM model of engagement hold the answer? Submission for MSc thesis/candidate No P3168.	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.
7. GAVI (2007). Improving GAVI's engagement and effectiveness in fragile states. http/ www.gavi.org	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 (www. 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.
8. Global Fund (2006). Paper on investments in fragile states: early results. (Global Fund Geneva) www.globalfund.org/fragilestates	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
9. Cassels, A. (1996). Aid instruments and health systems development: an analysis of current practice- Cassels, A, in Health Policy and Planning 1996.	9. While not post conflict specific- the purpose of paper is to develop a framework for analysing and provoking discussion about effectiveness of aid in health sector. Includes: changing agenda for health system development and reform, objectives of donor assistance and typology of aid instruments. Highlights advantage and disadvantages (See table 2 for summary p.366) of different forms and suggests they should be complementary depending on development objectives most appropriate for the context.
10. OECD DAC (2006). Aid harmonisation and alignment; bridging the gaps between reality and Paris reform agenda. www.oecd.org/parisdec	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."
11. Mc Gillvary, M. (2007) Analysis of deviations and delays in aid disbursements (UNU WIDER discussion paper)	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.

Author/Title	Brief abstract of key findings
12. Capobianco, E. (2007). A Review of Health Sector Aid Financing to Somalia (2000-2006) (World Bank, Washington).	12. 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, Somalialand and Puntland). Excellent and perhaps the only full scale analysis of aid trends to the health sector in fragile state contexts.
13. World Bank LICUS (2006). Engaging FS – Independent Evaluation Group. Review of WB support to LICUS countries	13. 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.
14. ODI/HPG (2006). Beyond the continuum; donor policy and aid effectiveness review (ODI, HPG paper) (www.odi/hpg.org)	14. 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.
15. World Bank (March 2007). Strengthening WBs Rapid Response and long term engagement in Fragile States (Operations Policy & Country Services Fragile States group paper)	15. 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.
16. IDA Paper; (2007). Operational approaches and financing in fragile states.	16. Looks at WB strategies used in fragile states and needs for improvement in financial arrangements.
17. Buse, K. and G. Walt (1997). ¢Un unruly mélange? Coordinating external resources to the health sector: a review' *Social Science & Medicine* Vol. 45, Issue 3, pp. 449-463	17. Recognition for need to coordinate aid to health sector (not specific to post conflict countries. Reviews existing donor coordination strategies (see summary table p.456) and its strength and weaknesses and highlights most are donor-driven rather than recipient led. It concludes no systematic review of which mechanisms work best in health sector, impact of contextual factors, motivation of actors and how coordination can make difference.

Author/Title	Brief abstract of key findings
Liberia	
1. Liberia Interagency Health Evaluation Report (September 2005). (IASC Geneva commissioned)	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. Liberia Interagency Health Evaluation Report (May 2007) Follow up to 2006 review.	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[1]. 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.

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

Author/Title	Brief abstract of key findings
Fragile states / post conflict and state building	
1. OECD DAC (2006). Principles of good international engagement in fragile states. Learning and Advisory process on difficult partnerships. At www.oecd.org/fs	1. 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. OECD DAC. (2007). From fragility to Resilience: Concepts and Dilemmas of State building in fragile states- 9th meeting DAC fragile states group.	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. Dealing with Fragile state entry points and approaches. Paper prepared for Bonn (2002) meeting. Accessed at website ;http://www.gsdrc.org/go/topic-guides/fragile-states/case-studies-and-success-stories	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). Useful matrix provided based on legitimacy and institutional capacity.
4. Brinkerhoff, D.W. (2005). Rebuilding governance in failed states and post conflict societies: core concepts and cross-cutting themes.	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. Health and Peace building: Resuscitating the Failed State in Sierra Leone.	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.

Author/Title	Brief abstract of key findings
Assessment tools adopted by donors/bilateral and humanitarian reform agencies	
1. Willits-King, B. (2007). Allocating humanitarian funding according to need: towards an analytical framework for donors. Discussion paper commissioned by Irish Aid.	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.
2. Humanitarian Aid in DAC Peer reviews- synthesis of findings and experiences 2004-05.	2. Summarises findings of peer reviews of donors on good humanitarian donor ship principles, utilising an assessment framework.
3. World Bank (2006). Transitional Results Matrix; Using results based frameworks in fragile states. UN Development Group. World Bank.	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)
4. NEPAD – Africa Post-Conflict Reconstruction Policy Framework (2005). New partnership for Africa Development. Accessed at http://www.nepad.org/2005/files/documents/114.pdf	4. Outlines purpose and objectives of NEPAD new policy framework for FS and definitions of transition are provided as operational definitions. Useful to gain insights into the Africa context focus.
5. Meeting Note: Seminar on Integrated Peace building Strategies (IPA, CID, 2007)	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.

Author/Title	Brief abstract of key findings
Conference proceedings	
1. High-level forum on the health MDGs (2005) Health in Fragile States: An Overview Note. Paris: November 2005	1. 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.
2. High-level forum on the health MDGs (2005) Health Service Delivery in Post Conflict States. Paris: November 2005.	2. 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	3. 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'

Donor	Definition	Criteria	Lists
AUSAID http://www.ausaid.gov.au	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 http://www.dfid.gov.uk	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

			25. Lao PDR 26. Nigeria 27. Solomon Islands 28. Zimbabwe
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.

		See DGIS policy note on Dutch Development Cooperation 2007-2011: http://www.minbuza.nl/binaries/en-pdf/080027_our-common-concern.pdf 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.	The main criterion for the security and development profile is **'fragility or major inequality blocking poverty reduction'** which includes the following countries: Afghanistan Burundi Colombia DRC Guatemala Kosovo Pakistan Palestinian Territories Sudan. DGIS development cooperation is to be phased out over the coming four years in the following countries which are considered part of this security and development profile: Bosnia-Herzegovina, Eritrea and Sri Lanka (only humanitarian relief in response to current security situation in Sri Lanka).
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)
OECD/DAC http://www.oecd.org/	No definition but the OECD's *Ten Principles of Good International Engagement in Fragile States* http://www.oecd.org/dataoecd/61/45/38368714.pdf	• post-conflict/crisis or political • transition situations • deteriorating governance environments • gradual improvement prolonged crisis or • impasse.	OECD DAC 2006 3 categories of fragile states **1. Marginalised Countries** Burundi Congo, Democratic Republic Guinea Nigeria Uzbekistan Yemen **2. Countries with high levels of need and weak governance** Central African Republic Côte d'Ivoire Liberia Myanmar Somalia Sudan

			Togo Zimbabwe **3. Countries with improving aid levels** Cambodia Chad Eritrea Gambia Guinea Bissau Niger Sierra Leone Tajikistan
UNDP http://www.undp.org/	LICUS (Low Income Countries Under Stress)		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

			34. São Tomé& Príncipe 35. Sierra Leone 36. Solomon Islands 37. Somalia 38. Sudan 39. Tajikistan 40. Timor Leste 41. Togo 42. Tonga 43. Uzbekistan 44. Vanuatu 45. Yemen 46. Zimbabwe
UNICEF http://www.unicef.org/	States that are not in conflict, sometimes have weak institutions and high levels of corruption, political instability and weak rule of law.		Active in 190 countries, no specific fragile state list
USAID http://www.usaid.gov/	"Fragile states" 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.	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	96 countries no specific fragile states

	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