Technical approach paper

Absorptive capacity of health systems in fragile states

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Abbreviations

AIDS:	Acquired Immunodeficiency Syndrome
DAC:	Development Assistance Committee
CPIA:	Country Policy and Institutional Assessment
DFID:	Department for International Development
DPC:	Difficult Partnership Countries
DRC:	Democratic Republic of Congo
GFATM:	Global Fund to Fight AIDS, TB and Malaria
HIV:	Human Immunodeficiency Virus
ITN:	Insecticide Treated Net
LICUS:	Low Income Countries Under Stress
MDGs:	Millennium Development Goals
NGO:	Non Governmental Organisation
RBM:	Roll Back Malaria
SWAp:	Sector Wide Approach
TA:	Technical Assistance
TB:	Tuberculosis
UN:	United Nations
WHO:	World Health Organization

Executive summary

The political imperative to address fragile states is increasing, and the needs are indisputable. However, the capacity to use increased donor funds effectively - the absorptive capacity - tends to be constrained by a number of factors.

Politically, the lack of agreement around the importance of poverty reduction, governance or human rights may be a problem, as well as a lack of accountability to citizens and/or endemic corruption. On the economic side, there are concerns about weak financial management systems, the fungibility of aid, macroeconomic impact, and diminishing returns in aid effectiveness. Practically, it is much more difficult to spend money well in fragile states: lack of infrastructure, systems and human capacity are all major problems, which in many instances are compounded by insecurity and the duplication of dysfunctional systems.

The problem is not one sided. Donor short termism, rigid adherence to over designed projects, and fragmented, unharmonised inputs can all be problems. Also, donors often experience difficulty in recruiting experienced staff to work in fragile states.

In addition to these general problems, there are also the specific issues related to health. Performance against the health Millennium Development Goals is generally poor. Home to 15% of the world's population, these states are where half all child deaths and a third of all maternal deaths occur. People living in fragile states are more likely to suffer ill health and die prematurely.

Facing these issues, what can donors do?

The design and approach to monitoring a programme should depend upon whether the first priority of a donor is to improve health outcomes, strengthen the health system, or catalyse broader societal change. The scope of the project should be proportionate to the investment - where donors are contributing a small proportion of the health budget, their impact is unlikely to be great. Although the risks of working through government may be greater, the potential benefits and influence are usually greater when it is possible to work in this way.

Whether to work with and through government systems will depend on political factors and the balance of perceived risks. Within all the components of the health system (stewardship, financing, resource management and service delivery) there is a spectrum of interventions between those that directly support government to those working totally outside it. The middle of this spectrum is where significant thinking and experimentation is occurring, and some of these more innovative approaches are likely to prove effective. Donors do not need to exclusively fund through either government or parallel/non governmental channels, and in most instances a blend (with variable proportions) will be most appropriate. It should be possible for essential needs (such as preventive health) to be met, with little risk of undermining broader and more strategic reforms.

Wherever possible donors should support the core stewardship functions - helping national governments to lead the development of a coherent and realistic health strategy, and to co-ordinate the various stakeholders. This is particularly important given the range of actors and instruments working in health, with overlapping and competing agendas - UN, bilateral and multilateral agencies, NGOs, and now also many global health partnerships. Strong leadership, effective priority setting and strategic capacity building are required. The needs for harmonisation and rationalisation of support in fragile states are particularly pressing, and may necessitate some agencies changing the way in which they operate.

It is important to think ahead and use evidence emerging from countries that have recovered from conflict and from other low income countries to develop approaches that reflect current thinking, rather than just try and rebuild what worked in the past. In particular, this means recognising that a major source of finance for the health sector is likely to be out of pocket, and that much of the delivery will be by the private sector. Donors must be prepared to invest in developing new roles and skills to reflect the new role of the state as it moves from monopoly provider of services to steward of the whole sector. Donors must recognise the increasing role the private sector will play, and consider how best to help the poor access services.

Some of the results that are emerging around performance related payments (from Rwanda, Democratic Republic of Congo and Cambodia) are encouraging. While a number of concerns persist, particularly about issues of capacity, limited competition and longer term effects on provider behaviour, donor funded co-payments seem to be leveraging major improvements in service utilisation, and decreasing out of pocket expenditure.

Provision of drugs and commodities can also be an effective intervention, particularly as international procurement can result in major cost savings and quality safeguards, and the risks of adverse macroeconomic impacts are fewer. However, this must be a long term investment with support to the distribution and management of these products, if massive waste and corruption or undermining of local systems are to be avoided.

Whatever approach is adopted, donors need to be realistic about sustainability. They should plan and finance over long time frames – whilst also allowing for frequent reviews, built-in flexibility and scope for redesign. Even where there is not an absolute shortage of resources, financial flows may be difficult, and if donors want to make a real difference they should not be squeamish about paying recurrent costs and supplementing salaries.

Health is a political process. Ultimately a sustainable quality service is ensured through the effective demand of people on their governments and on those responsible for providing services. The accountability of the governments of fragile states to their constituents is often lacking. Although experience of working on the “demand side” is limited, donors should look for opportunities to support the provision and dissemination of information, to work with civil society and professional groups that are trying to improve service quality and accountability, and with those working on participatory monitoring and budgeting and other “tools of accountability”.

Development is also a political process, and whilst economic growth is a key component, it is not the only objective. Much of the assessment of aid effectiveness suggesting that aid is only effective in good policy environments focuses on economic benefits, and does not consider other, less tangible benefits relating to service provision, human rights, corruption and resource management issues. Economic and political developments do not necessarily occur in parallel. Substantial changes in fragile states can take a long time, and sometimes time and investment can be required to lay the foundations of reform before more tangible improved outcomes can be achieved.

Whilst most donors have adopted a lower risk strategy of minimal engagement in fragile states, and have channelled most of their assistance through NGOs where they do engage, there have been successful exceptions. The unprecedented volumes of aid that are being allocated to health, and the escalation in the quality and quantity of analysis around investment in fragile states, mean that there are opportunities for major progress if these two forces can be brought together and translated into strategic action.

1. Introduction

What can donors do for the health sector in fragile states? This paper outlines some principles and approaches that can help to address absorptive capacity constraints, and to support long term development of health systems.

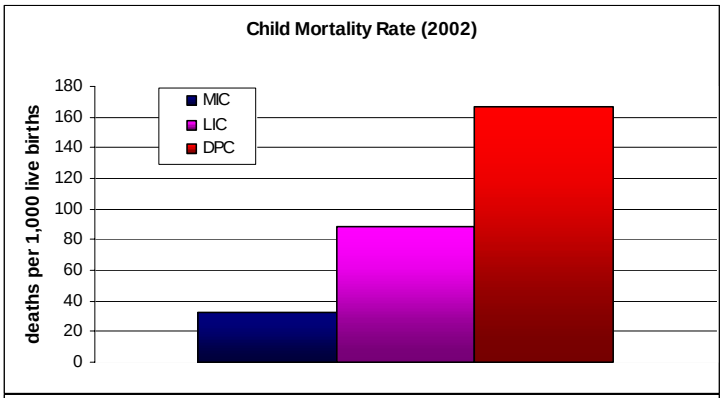
It begins by looking at the broad context and at the multiple challenges - political, economic and practical - faced by donors. Moving to the health sector, the paper highlights the key issues and offers ideas and suggestions for donor engagement.

Definitions

There is no universally accepted classification of "fragile states". Different definitions are in use, reflecting different organisations' priorities. The UK's Department for International Development (DFID) has a working definition of fragile states as "those where the government cannot or will not deliver core functions to the majority of its people, including the poor"[1]. The Centre for Global Development in the US has a list assessing states in terms of security; Rotberg proposes criteria to distinguish weakness, failure and collapse[2], while the DAC assesses the nature of the development relationship. Another definition in use is that of "Difficult Partnership Countries" (DPC). The World Bank (through its Country Policy and Institutional Assessment scores) focuses on economic development; countries with a particularly low CPIA score are defined Low Income Country Under Stress (LICUS). There is substantial overlap between the lists, and a core of countries (Afghanistan, Angola, Democratic Republic of Congo, Myanmar, Niger, Nigeria, Somalia and Sudan) that appear on many or all.

Challenges for health

Fragile states are home to 15% of the world's population, and are where half of all child deaths and a third of all maternal deaths occur[3]. People who live in fragile states have much worse health outcomes than those who live in neighbouring countries. The graphs in Figure 1 show an analysis of the performance of low and middle income countries, and fragile states in critical health related areas. Although based on relatively small numbers and poor quality data, these stark differences reflect the impression that one gains on visiting these countries, that is of a total collapse of basic services for much of the population.



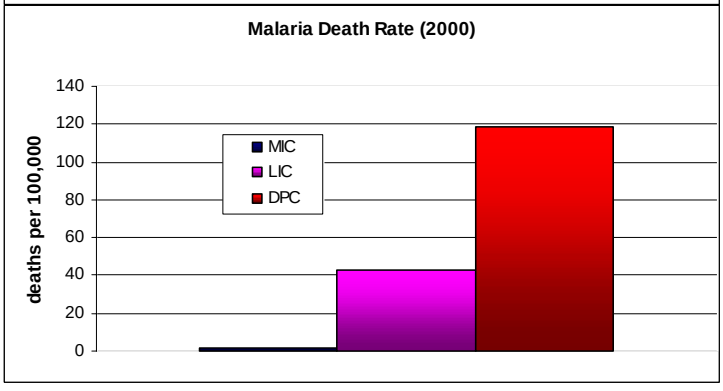


Figure 1:

Comparison of critical health outcomes by recipient group

DPC: Difficult partnership countries
LIC: Low income countries
MIC: Middle income countries

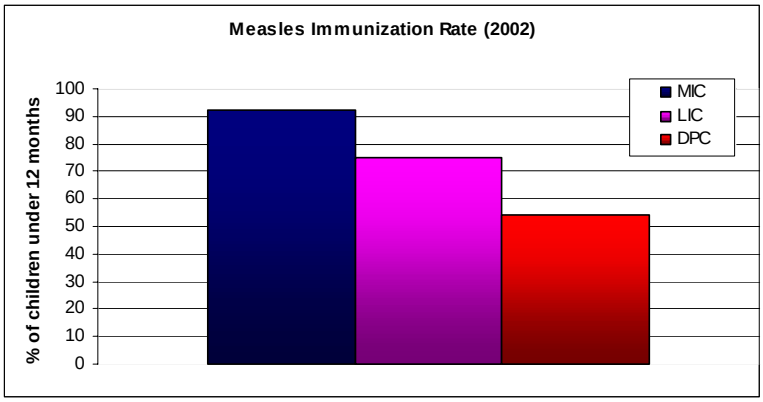
(Source: Levin 2004; continues on next page)

[1] DFID, 2005b
[2] When states fail, 2003
[3] Branchflower, 2004

Figure 1

DPC: Difficult partnership countries
LIC: Low income countries
MIC: Middle income countries

(Source: Levin 2004)



If the international community is serious about addressing the Millennium Development Goals (MDGs), there has to be progress in these countries. There is a real political commitment to increase aid flows, but a real challenge remains – how to spend the money effectively. The current development paradigm is based upon partnership, and over the last decade attention has been focused upon the "good performers" within this context. A major reason for this has been Burnside and Dollar's work[4] suggesting that aid only enhances growth in good policy environments. While this may be true, there may be other less tangible social and political benefits that are also important, and may be prerequisites to improving the policy environment.

Understanding the political context and the incentives that are operating is crucial. Aid, health and politics are inextricably linked. There is a perception that working in health and attempting to save lives is politically neutral. However, as one shifts from humanitarianism to development, concerns of sustainability and "ownership" increase, and broader systemic issues and constraints rapidly emerge. These need to be understood and actively managed if naive and simplistic recommendations are to be avoided. It is vital to understand the background and causes of fragility, to avoid compounding and perpetuating problems, and develop lasting solutions.

Having said this, there are common issues and approaches, and whilst specifics vary in most fragile states, the problems are a combination of ethnic fragmentation, neopatrimonial politics, over reliance of the economy on natural resources, conflict and corruption[5]. Although there is a group of countries that most observers would confidently classify as "fragile", there is a much greater number that demonstrate some, but not all of the characteristics of "fragility". Absolute definitions are not helpful, and how a country is classified will depend upon when and how one looks at it. Just as the countries exist in a continuum of fragility, so should the responses and aid instruments used to support them. Sometimes there is a clear distinction made between "post conflict states" and the rest. There are differences: war creates special problems and needs. Occasionally peace settlements can create national unity and a strong accountability of government to its citizens, resulting in rapid progress in development. In general the overlap is substantial. Conflict is often a manifestation of underlying fragility, and peace settlements may not deal with underlying problems.

Over the last five years, donors such as DFID and USAID, and organisations such as DAC and the World Bank have published excellent strategy and policy documents, including the *Principles for good international engagement in fragile states*.[6] There has been much less work at sector specific levels, or analysis of the practical challenges of operationalising these ideals. The real challenge for these donors over the next decade will be to translate policy papers and good principles into robust approaches on the ground.

[4] Aid policies and growth, 2000
[5] Moreno Torres, 2004
[6] 2005a

2. Can aid be delivered effectively in fragile states?

The issue

Using development money effectively in fragile states is difficult. Concepts of "partnership" and "ownership" are particularly tenuous in these contexts. When donor and recipient countries do not share priorities or aspirations, the concept of partnership is difficult. Donors want government to be "in the driving seat" – but there has to be agreement on the destination and the route. Donors are attempting to limit their fiduciary risk by strengthening domestic accountability within the recipient country[7], but one of the characteristics of fragile states is that the compact between government and citizens, around which such accountability is based, is weak or absent.

The optimism required to see the donor-recipient relationship as a partnership, and to work through the sorts of aid instruments (such as budget and sector support) that allow the rapid transfers of funds to recipient countries, is stretched even further in many fragile states. In a (relatively small) group it is not realistic at all. Where systems are really weak, the capacity to use money well is limited. Alternative mechanisms will be required if donors want to make a substantial investment, or at least one proportional to needs.

Large sums of money can be spent effectively if the donor is prepared to take over responsibility for service provision, as with traditional humanitarian assistance. In the long term however this is neither politically desirable nor sustainable in economic terms.

Donors invest in health for a range of reasons: sometimes for immediate gains in mortality and morbidity (often reflected in the current focus on the MDGs), sometimes in the hope of developing a more sustainable and effective health system, and sometimes as a part of a broader agenda of improving the stability, governance and economic performance of a country. Each of these represents different objectives for development assistance and each may require different sets of aid strategies and instruments.

Where donors are trying to bring about change at a systemic or societal level, the context in which they are operating, and the degree of resistance within the system can be a particular problem. Helping something change that wants to is easy. Forcing change against established resistance is much more difficult.

Are there alternatives to the current "partnership" paradigm? Would a more "business like" or contractual relationship be more effective at influencing change? Private sector companies operate very successfully and profitably in many fragile states (even if they acknowledge a greater risk).

Given all these difficulties, is it worth donors trying to work with fragile states? Can they, and do they make a difference? The needs and potential benefits may be enormous, but is there an effective way to channel and use the donor resources available? This paper will seek to answer some of these questions.

What should be done?

Historical and economic analysis suggests that without international intervention, the situation within fragile states is unlikely to change. Paul Collier's analysis suggested that the chance of graduation from LICUS (Low Income Country Under Stress - a classification broadly synonymous with Fragile) is about 1.7% per year. To put it another way, once a country becomes "fragile", it will remain so for about 50 years[8]. The costs of this are enormous – not only to the citizens of that country, but to neighbouring countries as well. Even a slight acceleration of positive change would represent substantial economic and political benefit. Donors and their political masters need to balance the increased difficulties and risks of operating in fragile states against the even larger risks of doing nothing.

[7] DFID, 2005a
[8] Chauvet and Collier, 2004

It is easy to cite cases of aid to fragile states being ineffective. This was particularly true during the cold war era, where Northern powers invested huge amounts in some developing countries, often fuelling conflicts. Interventions such as Lifeline Sudan have been implicated in prolonging conflict. But although it is difficult to demonstrate causality, in countries such as Sierra Leone, Rwanda, the Balkans, some parts of the former Soviet Union and probably Afghanistan, a strong case for positive impact can be made.

There are international imperatives for action. Over the last four years, global security has moved rapidly up the international agenda[9], and the fact that fragile states may foster terrorism and international crime is another potent stimulus to action (even if there is an associated risk that this might result in redirection of resources away from areas of greatest need). Investing in health is of course a benefit in its own right, as well as a necessity for an effective, productive society. There is a growing realisation that the Millennium Development Goals will not be attained without significant progress in some fragile states[10].

Partnership and support through government systems is more difficult in fragile states, but there are examples where it has worked well. British budget support to Sierra Leone was important in stabilising the situation and initiating rapid scale up in service delivery. Swiss budget support for the health sector in Mozambique was very effective (although a similar approach in education failed).

There should be no discontinuity between humanitarian and development funding. Donors should reflect the continuity in the transition between war, instability and underdevelopment in their funding streams. Transitional funding should be longer term, introduced before humanitarian aid finishes, and should continue for years as the capacity to use funds through development instruments such as sector wide approaches and budget support is developed.

All the analysis suggests that the absorptive capacity of government systems in fragile states is initially very low, and the prime need is for excellent technical assistance in core areas such as policy development and basic systems. Too much money too early to government may be counterproductive (even though some is desirable). Donors should channel substantial funds in a manner that miminises the disruption of broader and longer term development, and yet offers useful development gains. This might include areas such as basic and preventive health services, which can be delivered and funded through a variety of channels.

Contractual type relationships are probably not the answer for relations with government. The international financing institutions have developed huge experience of “conditionality” over the last few decades, and there is an emerging consensus that enforced conditionality is rarely effective. This is probably particularly true in the social sectors. What can donors do if a recipient government does not deliver? Of course the programme can be suspended, but this will hurt the potential beneficiaries (usually the poor) and will probably have minimal impact on government.

As regards service delivery through the non government and private sector, there is probably much more scope. In many developing countries most services, including those for poor people, are delivered through the private and NGO sectors. In fragile states, where state provision has collapsed and an entrepreneurial culture is necessary for survival, this proportion is usually even larger. The capacity is there, and it will respond to financial incentives. The challenge for donors is to recognise its importance, understand how it operates, and develop and scale up ways to work with it in a manner that enhances the quality and affordability of the services that poor people can receive.

[9] See the report of Secretary-General’s High Level Panel on Threats, Challenges and Change “A more secure world: our shared responsibility” (2004)
[10] High Level Forum on Development Effectiveness and Fragile States, London, January 2005.

3. What constrains absorptive capacity?

In fragile states, the capacity of donors to use increased funds effectively is constrained by several factors, practical, political and economic. This section provides an overview of both the internal factors and the donor practices that often exacerbate existing problems.

"In country" factors: political, macro-economic and practical

Political factors

One way of looking at states is to characterise them according to their capacity and willingness to deliver pro-poor policies. Fragile states are lacking in one or both of these elements. As mentioned earlier, most current development instruments are designed to support a government's own programme of social and economic development. Whilst international and domestic priorities will invariably differ, a productive relationship can develop where there is substantial overlap. If attitudes and actions diverge too far, then the donors are not in a position to "get behind" government, and channelling funds through, or in support of established systems and policies is not an option. If government is not committed to effective service delivery, then the institutional environment, the incentives and all the other factors that actually help things to happen may also be lacking.

Of course formal government systems can be largely irrelevant in many fragile states. The private sector (formal and informal) and community based organisations can be very significant in terms of service delivery and as partners for donors. For example, in its "Drivers of Change"[11] analyses, DFID has started to look much more strategically at how it can engage with other agents in a country to support pro-poor change. Such collaboration can be very effective where it is supported by government. It is more problematic in the cases where government-donor relations are poor and there is not even tacit support or acceptance of this way of working.

The relationship and accountability of government to its citizens is fundamental to democracy. In many fragile states government accountability to at least some sectors of the population may be minimal, and this is part of the problem. This may be compounded by aid, if recipient governments become more anxious to respond to donor demands than to those of their own constituents.

Corruption is another major problem in many fragile states. It means that the real cost of doing business and achieving change may be significantly higher than anticipated, because of kickbacks. Much more significantly, it changes the way in which donors are prepared to operate. Because they are accountable to their own citizens, and are concerned that aid money will be stolen, donors are rarely prepared to put their money through the systems of really corrupt governments. Where they do, the strategy that the donors impose to limit illicit activities can significantly impede legitimate spending as well. This is something that donors may find difficult to address, since people benefit from corruption – indeed in many countries government officials survive on it. There is little incentive for workers in a fragile state to improve a system if their livelihood is based upon receipt of bribes because the system does not work. Superficial reforms and changes are welcomed, but very often donors may find it impossible to effect fundamental changes in the way that systems work, when this may limit the scope for rent seeking.

Macro-economic factors

Additional resources are generally much more useful when they are predictable. Aid flows are estimated to be seven times less predictable than domestically generated revenue[12], and twice as volatile again in fragile states as in other low income countries. A DAC study has shown that volatility is sometimes related to conflict resumption, but largely to changing donor priorities[13]. Aid cannot be used for strategic investments, or for supporting long term change, if it is only offered for a year or two.

Within fragile states there is often a generalised lack of resources. Even where there are nominally significant resources, weak financial management may mean that they are not available at the right time. Without the resources to keep systems running, donor money that is earmarked for a specific additional activity cannot be used effectively.

[11] Available at http://www.grc-exchange.org/g_themes/politicalsystems_drivers.html
[12] Bulir and Harmann, 2003
[13] DAC 2005b

Where financial management is weak, donors face a quandary. The easiest solution is to establish parallel systems for disbursement, or offer technical assistance alone so that the "government never gets its hands on the money". However, in doing this they lose the legitimate opportunity to try to intervene and strengthen the established systems, and in fact they can also further undermine the systems that exist.

A major problem is that all aid is (at least to some degree) fungible[14]. Irrespective of whether money flows through an established or an additional channel, governments can use donor funds to replace their own expenditure. There is a risk that donor funds can effectively result in increased expenditure on defence or other areas that have no benefit to ordinary people. Furthermore, if governments decrease their own budget for areas like primary health care and education, there is no guarantee that they will necessarily increase it again if donor funds dry up. Given the weakness of financial management in many fragile states, it is often difficult to establish what has actually been spent, and to try to track resource flows.

Theoretically, the other economic constraints to absorptive capacity apply equally in fragile states. There is a risk that large aid flows might undermine macroeconomic stability[15] and have a negative impact on exchange rates. The law of diminishing returns in aid effectiveness does still apply. However, according to most analyses, most fragile states are under-aided. Collier's analysis suggests that in "normal" low income countries under stress, aid up to 20% of GDP can be effectively used – far in excess of existing flows to most fragile countries. Where they are receiving very large aid flows (e.g. to support post conflict reconstruction), political imperatives supervene.

Infrastructure and capacity

It is much easier to spend money well in a country where there is capacity, infrastructure and where systems work. In countries such as Southern Sudan, where there is no established banking system, no metalled roads outside major towns, and government capacity is really limited, the practical challenges of getting things done are enormous.

The lack of skilled staff is a huge constraint. Within a fragile state, many of those with transferable skills will have emigrated, others may have been killed, and many of those who remain may be working on project management for NGOs. As for the rest, capacity may be limited, and rebuilding the skill base and the work ethic may require years of investment.

Insecurity and a very weak rule of law is another problem, whether or not countries are emerging from conflict. This increases the risks and costs of any operation.

Those who have worked in fragile states or difficult environments will be familiar with the adage that it usually takes twice the time and effort that one expects to achieve anything. Capacity is limited, communications and infrastructure are poor, a web of petty corruption and perverse incentives has to be negotiated, and there is no apparent urgency to do anything. On this basis it would be sensible for donors and government to focus on a few critical issues. This however needs to be balanced against the multiple, complex needs that exist.

In many fragile states the problem is not that a system does not exist, but rather that it is over complex, and made more dysfunctional by multiple attempts to bypass and repair it. Donors' capacity to act and to spend their money effectively may be constrained by the complexities of government systems, and by the need to intervene in multiple areas and at multiple levels in order to make a difference (any plumber will tell you that in a system with multiple blockages, clearing a few is not going to make much difference to the flow rate). Very often actually understanding the system may be a major challenge, since, particularly in fragile states, the disconnect between business as it is done, and the official system may be large. In Nigeria, during the late '90s the accounting systems for local authorities should have been quite effective, but they were rarely used and cash was allocated without record, at the chairman's discretion[16].

Prioritising action, and resolving the tensions between the need to act on multiple fronts and the capacity to act on a few, is one of the arts of successful development.

[14] See HLSP Institute, 2005 (Module 4)
[15] Bulir and Lane, 2002
[16] Cameron, 1999.

Knowing what to do and when is also important – many things have to be synchronous, while others have to be phased if maximum benefits are to be accrued. The very positive impact of abolishing user fees for health care in Uganda has been widely publicised. However the observed increases in utilisation were a product of much wider reforms: increased availability of drugs, incentives for health workers, and a communication strategy. Cutting fees in Kenya has had very much less impact, and may have been counterproductive in Zimbabwe and South Africa[17].

It is also important to remember that many of the factors that have constrained the development of the fragile state in the first place, will similarly constrain donor assistance. It is much more difficult to operate effectively in a country where the population speak many different languages, large parts of the country are physically inaccessible, or educational and health status are low.

External factors: donor practices

While there are many factors within fragile states that constrain donors' ability to use their funds effectively, donor practices can frequently compound the problem.

Donors' expectations are often over optimistic and short term. Making change happen in fragile states takes time and effort, and predictable financing is much more likely to be effective. The transition between humanitarian and development spending is frequently poorly managed. Very often there is a hiatus between the two funding streams, at exactly the time when the absorptive capacity is greatest[18]. Donors continue to offer short term funding flows. Humanitarian donors operate in time frames of a few months, even when the realistic expectation is that needs will continue for years. The uncertainty over whether funds will continue is a major strain on agencies and the recipients of services, compromising the capacity to scale up operations or operate in a strategic manner. Even the part of an agency responsible for development will usually only operate, at best, on three-year project funding cycles – some will only guarantee funds on a year to year basis. A three-year project with two extensions of a year each is much less likely to have sustained impact than a project that is planned for five years in the start. The opportunities to spend wisely tend to accelerate over time, and stop-start will limit these opportunities.

Of course aid is a political instrument, and giving aid to the governments of fragile states can be politically sensitive. Domestic support to donors is important and fickle, and special interest groups can exert undue influence on the political process. However, short term reactive swings in aid flows are frequently counter-productive.

Whilst sustainability may be a long term objective, in the short to medium term most low income countries are not going to have adequate resources to provide quality services to their entire population. Despite this, some donors refuse to pay running costs. They will rather invest in capital projects (which very often increase recurrent expenditure further) and then worry why these facilities are not maintained. Some donors spend large sums on consultancies to develop and support systems, but fail to see the expected benefits because there is not enough money within the system for it to function.

Donor practices can prevent aid being spent effectively. High transaction costs and long delays mean that many opportunities for effective investment are lost. It can take over a year for some projects and programmes to be approved, and even once this is attained there may be further complex administration requirements before funds can start to flow. Donor projects are often "over-designed". The resulting lack of flexibility limits opportunities for effective intervention and investment. When the project itself is only meant to be of three years duration, it is not surprising that the rates of spend are lower than anticipated. Much development assistance is still "tied" - meaning that it can only be used to source things from the donor country. This can be a particular problem if there are only limited suppliers from that country, and they have limited capacity or interest in operating within a particular state.

Fragile states are often not particularly popular places for donor staff and consultants to visit. Insecurity is a problem for staff and their families. At least until recently, work in fragile states has not been linked to career progression. Recruitment is difficult, and often additional inducements are required. Very often development agencies send staff to fragile states "on promotion", even though these are really the

[17] Pearson, 2004
[18] Collier and Hoeffler, 2002

countries that require the most experienced staff, who understand how agency procedures should work, and then how they can be adapted to work effectively in a more difficult context[19].

Donor activity within fragile states is often fragmented. In countries emerging from conflict and humanitarian assistance there may be a legacy of disconnected interventions. In the face of a plethora of problems and the absence of an effective government strategy, donors develop their own, often disjointed, responses. Indeed the government of a fragile state may actually prefer donors to operate independently, as this increases the scope for double charging for activities, and playing one donor off against the others. But given the limited capacity for any change at all, this disconnected, piecemeal type of input can be exceptionally unhelpful.

What should donors do?

Donors must be realistic about their objectives and ensure that they are proportionate to the scale of investment. DFID might be able to expect significant change as a result of a £20m investment through budget support for Sierra Leone (which has a population of about five million), while a similar sum is unlikely to have so much impact in Nigeria, where the population is over 130 million, and the amount represents less than half a day's oil revenues.

Working in fragile states is intrinsically a high risk activity. Donors need to acknowledge this, get much better at assessing and managing risk and then live with it and avoid being deflected and over influenced by short term setbacks. Aid flows must become more predictable – with commitments of five to ten years. The expectations of politicians and the domestic audience need to be appropriately managed. The rhetoric of development is always about progress, whilst in reality situations can deteriorate dramatically. In many situations there needs to be an acknowledgement that "stopping things getting worse" is a major achievement in itself.

Politics is also complex within fragile states. There may be multiple agendas operating on different levels, and it is easy for donors to become unwitting pawns or set up perverse incentives. Donors need to be much more aware of the political sensitivities and of the disconnect between the formal system and how business is actually done in country. They need to think about the impact of their activities on both. Political realities can be harsh - a government may not give much attention to maternal and child health because surviving or maintaining territorial integrity consumes all its energies. Donors should be sensitive to this. In the long term, the prevention of civil war may be the best way to ensure child survival.

Understanding what is going on and why is difficult. Donors wanting to make a quick impact may assume that there is not much going on, or decide to bypass the existing system and set up something new. This is usually a mistake. The established system will continue to consume energies and resources. Fragmenting a system probably decreases the chances of any part of it working properly, and the new system may undermine existing forms of service delivery. It is far better to try to work out what there is, and focus as much on the "why services are still continuing" as on why things are not happening. Identifying and harnessing existing incentives is likely to be more efficient and sustainable.

Donors' relationship with the recipient government determines much of the nature and scope of their investment. The decisions around whether or not to work with and through government systems are based in part around the strength of those systems, but also around how strongly the donor government wants to support the recipient, and the political acceptability of a partnership on both sides. Another factor is the donor's judgement of the scope and potential benefits of influencing the recipient's own systems.

As part of efforts to increase aid effectiveness there is a general trend towards increasing alignment with countries' priorities and working through government systems[20]. Most agencies still feel that for political and programmatic reasons this is not realistic in fragile states, but there have been notable exceptions: DFID provided budget support to the Sierra Leone government, countries such as Nepal, Yemen and Papua New Guinea are moving towards sector wide approaches, and some countries – such as Uganda and Mozambique - moved relatively rapidly from post conflict to budget support.

[19] World Bank, 2002
[20] See for example the Harmonisation and Alignment Update by the HLSP Institute (May 2005).

There is obvious alignment of resources when support is provided 'on budget'. There have also been many examples of successful sector wide approaches where resources were not pooled, but priorities, systems and monitoring were "aligned".

Even if full alignment is not possible, or formal structures are not yet established, working alongside government systems, respecting factors such as geographical boundaries, systems and reporting time frames, is a supportive and in the long run potentially more sustainable way forward. Donors should harmonise their inputs, sharing reporting and procurement requirements, and where possible developing common approaches to implementation. In post conflict Uganda donors divided the districts among themselves, and then worked in quite different ways, which posed a real challenge for the government as it attempted to co-ordinate and then consolidate inputs. Something similar is currently happening in Afghanistan, where donors have each taken responsibility for a part of the country, and while they are all developing contracting schemes, they are using different approaches and models.

Donors must be aware that large volumes of aid can fuel corruption. The desire to disperse aid rapidly should not be an excuse to undermine anti-corruption measures, and robust systems to minimise the opportunities for corruption should be developed and maintained.

There is much talk of "early wins". Where relatively simple interventions exist that will make a significant change, it is obviously sensible to invest in them. However, in most cases if such solutions exist they will already have been tried. Donors' agendas in fragile states are littered with "quick win" or "early start" projects that are still foundering several years after inception. The quest for these projects can consume management time that may be better used in longer term activities.

In this area, as with everything else in a context where capacity to implement is so limited, it would be better to focus as much as possible on those few key areas, and on a scale that will really make a difference. There is little point in undertaking small scale projects, with relatively high transaction costs and minimal impact. Pilot projects should only be undertaken if there is a realistic plan for scaling them up rapidly.

Even where there are major divergences in policies and priorities, there may be scope for partnership in some areas. Many countries are working with the international community around HIV and AIDS. Programmes with a relatively narrow focus are at least an entry point.

Getting high quality, experienced staff to stay for a sufficient time to have an impact in fragile states is a real challenge. Agencies need to value staff who have this experience. They might weight fragile state experience in promotion decisions, particularly as so many of the skills and experiences honed in a difficult environment are important in most developing countries. Whilst there is a real benefit in having staff based in these countries, there are numerous examples of very productive relationships that have been developed with experienced consultants visiting over a number of years. This may be the only way to obtain sufficiently long term inputs from high quality staff, and in some instances it may be beneficial as it prevents the development of over dependency.

4. Why engage with the health sector?

Given the complexities of development in fragile states, are there any specific issues associated with health that make things more or less difficult? This section looks at some of the characteristics of the health sector, and offers general principles for donors' engagement.

What is special about the health sector?

Inter-relatedness

Provision of basic health services meets a fundamental human need, and this sort of "humanitarian" intervention can be seen as less threatening and intrusive than other types of donor intervention. There has been major progress in the development of sector wide approaches in the health sector in low and middle income countries, and there are examples of sector budget support "leading the engagement" in fragile states. However, the determinants of health and the interventions that really make a difference to health care delivery are closely linked to much broader issues. It is rarely possible to work in a strategic way with the health sector in isolation, as the failings of the key components of the system (such as human resources, procurement, financing, or regulation) reflect more general weaknesses that are only tractable at higher levels.

Complexities

Health systems are complex, and the links between inputs and outcomes are subject to multiple influences and confounding factors. Quality is difficult to assess, demand is intermittent, and there is a wide range of powerful stakeholders whose priorities may differ from the international/MDG agenda.

Vertical programmes and global partnerships

The breadth, complexity, and risk of competing agendas across the health sector has meant that many governments and donors have preferred to focus on specific diseases and developed a range of vertical programmes. These have received a boost over the last five years with the proliferation of global health partnerships – together with new funding instruments that seek to consolidate and channel resources for specific diseases. There are now over 70 such partnerships in the health arena alone. They tend to rely on countries' own systems for much of their implementation, and have minimal "in country" presence. These are issues in fragile states where the lack of capacity to implement anything is a major constraint, and where the political complexities and relationships between donors are particularly complex and fast moving[21]. Whilst there are examples of programmes, such as the Global Fund to Fight AIDS, TB and Malaria, operating relatively successfully in very difficult areas, it is still too early to draw firm conclusions[22]. The Global Fund has been able to mobilise a range of actors to develop protocols and systems, but whether these will be successfully implemented is yet to be seen.

Principles for engagement

Donors need to be clear about their objectives. They may hope to improve health outcomes in the short term *and* effect a transformational change in society in the longer term, but they should clearly state what the highest priority is, and design a programme and indicators for monitoring this accordingly. If a donor's real objective is to achieve a change in the way that the health system operates, then this needs to be strategically addressed. For any change to be successful and sustainable, it has to be locally owned and locally driven. External imposition of change is likely to be counterproductive, and in a politically charged environment it may be political suicide to be seen as the "donor stooge".

As mentioned earlier, the decision whether to work with or outside government is political, and a judgement that donors make on a range of complex factors. There are multiple ways in which donors can work with and outside government, and there is growing sophistication around "intermediate approaches" which are particularly important in fragile states. A number of these are examined in more detail in the next chapter.

Where donors are developing sector support programmes, these must reflect the knowledge and experience that has been accumulated over the last decade around SWAps in low income countries.

[21] Caines, 2004
[22] GFATM, 2005

Most of the lessons are transferable. It is particularly important that both sides are aware of the time and effort that must be invested on both sides if the approach is to work. This is likely to be even more important in fragile states, but donors are used to working on short time frames, and expecting (although not getting) rapid results.

Reform to systems will only occur where there is a will and a locally owned and driven agenda. Where these are lacking, donors may have to engage differently on systems/reform issues: for example supporting change agents, and the collection and dissemination of information that creates debate and the demand for more fundamental changes.

Whilst the whole sector may need support, there may not be the capacity to engage across the sector, or to develop and/or reform so many areas. So focus is important. It is easy to get bogged down in a plethora of small activities across the health sector. The challenge is to identify the political and epidemiological opportunities where the greatest gains can be made – either in terms of burden of disease, or of systemic change.

Vertical programmes are frequently criticised for undermining the overall health system. However in some fragile states it may be much easier to motivate people around particular issues. It is better to get some services running, rather than attempt comprehensive provision and bring everything down to the lowest common level. The rhetoric about vertical programmes acting as "pathfinders" for broader reform of health systems is rarely substantiated. At least, where donors are supporting the development of specific programmes, it would be sensible to establish systems that are potentially coherent and compatible with a broader range of functions, and that do not impede or distract attention from other high priority programmes. Global health partnerships, or some of their partners, need to develop a different approach to fragile states, with a more hands-on role, better monitoring and more strategic approaches to the fundamental constraints around effective implementation.

As a general principle, offering "what people want" (such as quality curative care for a limited range of common, important conditions) is a useful entry point[23], particularly if the donor is interested in health system development, or in supporting the credibility and stability of the government. This should work with and through established systems where possible – in particular recognising that NGOs and private practitioners may have been the major providers of service through a crisis, and are likely to become more sustainable in the long term.

This approach will not adequately address preventive interventions. There are many interventions, such as immunisation, provision of insecticide treated nets, hygiene promotion and oral rehydration for diahorrea, contraception and condom provision for HIV prevention that have a major impact on the health of the population, are cost effective, and can be delivered through a range of channels (e.g. government/NGOs/social marketing). These interventions will require long term public subsidy, by government or donors, and can probably be delivered through parallel channels, with less impact on the development of the stewardship function, and on the broader health system. As such these services are particularly important for donors that do not, or cannot work through government systems, and for those countries willing to work with the international community, as a mechanism to provide additional resources where there is limited absorptive capacity.

[23] Nabarro 2005

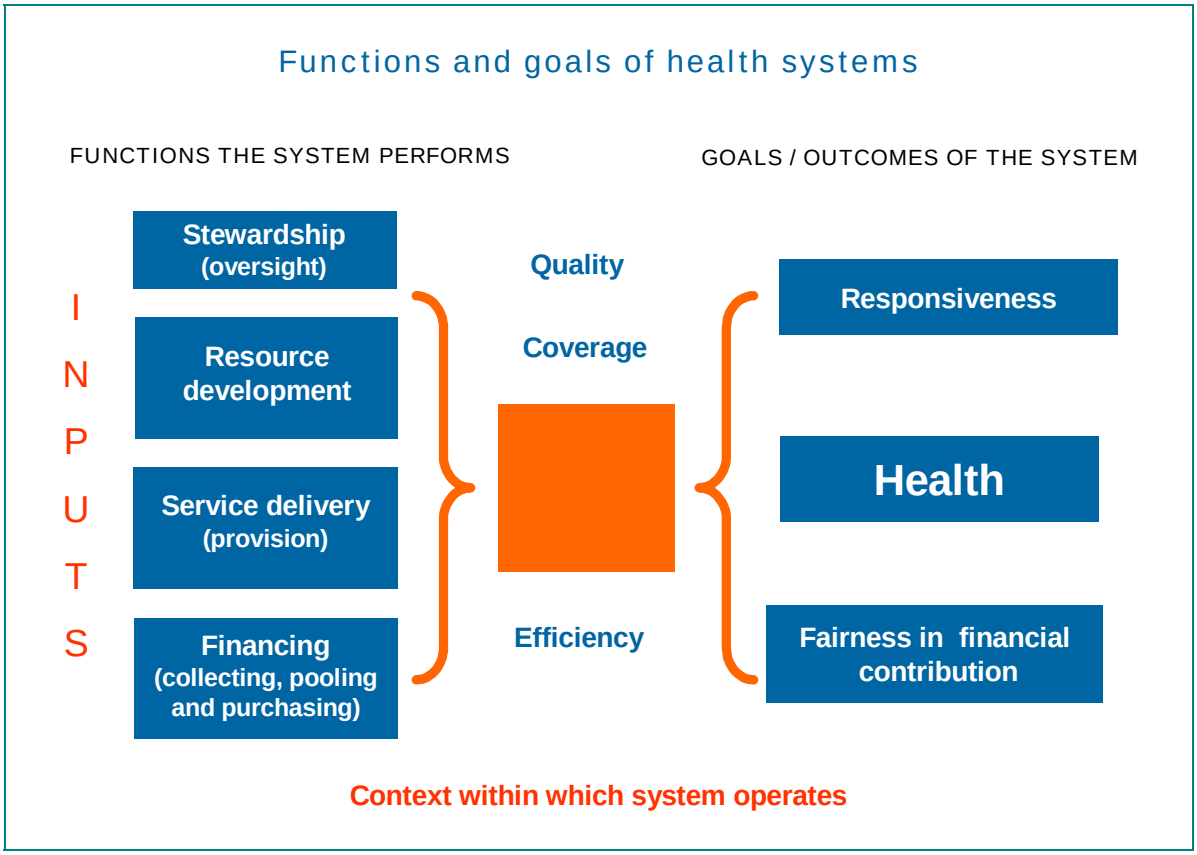
5. Approaches for supporting health systems

Health system components

Health care is reliant upon a health system – irrespective of who is paying for it or providing it. In addition to the delivery of services at facility level, there need to be effective systems for managing resources (drugs, facilities staff), effective financing systems, and an appropriate policy and coordination system. The quality of service delivery (whether in the public or private sector) is related to how well these different components are co-ordinated. Co-ordination and the key components tend to be weak within fragile states, and these weaknesses tend to undermine the absorptive capacity of the overall system.

Although the components of a health system cannot be viewed or reformed in isolation, the WHO model of a health system (Figure 3) is a useful way to describe its key functions and how they do, or do not fit together.

Figure 3: The WHO model of a health system



(Adapted from WHO, World Health Report 2000)

Working with the different components of the health system

There are many ways in which donors can work for these individual components of the health system. As well as choosing to support a specific function, donors can work on these areas entirely with or outside government, or in an “intermediate” way. For example, a donor wishing to support commodity supply has a range of options. Working with the government, it can support central medical stores or government procurement of drugs. When this is not possible or desirable, social marketing programmes of simple commodities (such as insecticide treated nets) are one way of bypassing the system without undermining it, and with tangible impacts on some health indicators. One intermediate approach would be to support government in contracting out specific functions (like procurement or transport for

example); another, to provide supplies in kind to government, in addition to technical assistance for strengthening supply management.

Table 1 provides a summary of the range of approaches that are available to donors. These, and the specific issues associated with supporting the individual components of the health systems are explored in detail in the sections that follow.

Table 1 - Approaches to working for the different components of a health system.

	With government	Intermediate approaches	Outside government
Stewardship/ Policy support	• Sector support • Technical assistance to government	Shadow alignment and harmonisation	• Projects • Focused support for specific issues
Financing	• On budget	• Shadow budgeting • Earmarked budget support	• Projects • Technical assistance
Commodities	• Support to Central Medical Stores/government procurement • Support to training programmes/ institutions	• Contracting out functions: procurement, transport, facility management • Supplies in kind and systems TA	• Social marketing • Projectised drug supplies
Service delivery	• Public service support (direct funded or via NGOs or private sector funded to give technical assistance and funds)	• Contracting NGOs or private providers through government • Performance related payment processes	• Contracting out to NGOs/private sector • Social franchising

Stewardship

Government has responsibility for oversight of the health system in its entirety, of public and private sectors including international donor and national NGO activity. It has to provide an appropriate, prioritised policy framework, and regulate quality. These are challenging roles, and within fragile states, many ministries lack the capacity or the will to perform them adequately.

Health is a political issue. All health systems in the world try to balance a range of priorities - ensuring the employment, interest and status of health workers, exhibiting national and local prestige through new health facilities, serving the vocal urban population, supporting people through catastrophic illness, as well as trying to improve the health status of the poor and vulnerable. Fragile states may lack the willingness or capacity to prioritise the latter objectives over others.

The traditional function of government is perceived to be providing services. The market in health care is rarely acknowledged and it is difficult for government to regulate and control the private and NGO sectors. Where the quality in public provision is poor, private providers may justifiably question the legitimacy of government to regulate the private sector. Indeed the state may be seen as a predatory body, with state officials using their position to elicit bribes.

Government should lead the co-ordination of donors and NGOs, but in fragile states the willingness or capacity may be lacking, and opportunities for rent seeking and double charging may be greatest within a fragmented system.

What to do?

The need for good stewardship of the health sector is arguably greatest within a fragile state, where resources are constrained, capacity is limited, and the need for good prioritisation, coordination and leadership is greatest. Whether for reform or reconstruction, the need for a clear plan to which all

subscribe is clear. International NGOs have identified this lack of leadership and coordination as an important and growing problem[24].

Where a government is "weak but willing" it will need active support in developing and undertaking this role. DFID has supplied long term consultants and worked through WHO to assist with policy and stewardship functions in countries such as Afghanistan and in the Balkans. Because capacity is limited, there will need to be considerable mentoring and long term technical assistance. This TA must be high quality and sustained: it is easy for short term consultants to offer solutions, but what countries really need help with is the implementation.

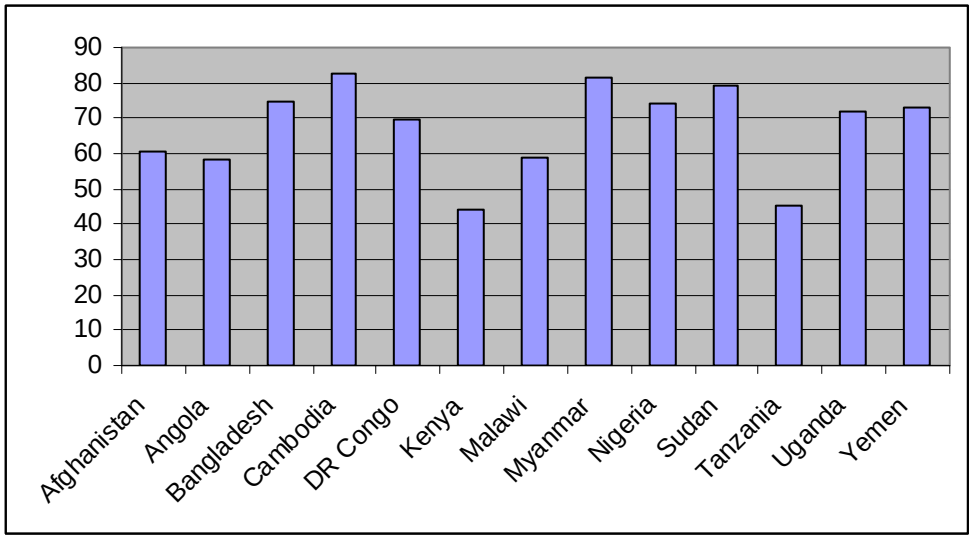
Where a government lacks the will to coordinate donors or work with NGOs, and is not developing a health strategy, donors should still harmonise their policies systems and activities. Where possible they should try to undertake "shadow alignment" arrangements. For example, if facilities are being constructed and services developed, it should be in a rational and co-ordinated manner. Sometimes this work is taken on by the UN. Where the capacity is lacking, another organisation needs to take on the role – leaving the NGOs to do what they are good at – delivering services.

Service delivery

Delivery of health care is reliant upon appropriately trained and motivated staff being available at an acceptable and accessible facility, which is supplied with adequate drugs and equipment. Ensuring that all these inputs come together consistently is a challenge that health systems in fragile states frequently fail to meet.

In developing countries the private and NGO sectors in health are huge, but largely neglected by governments and donors. National Health Accounts for low and medium income countries demonstrate the extent of private expenditure on health. Most of this is out of pocket expenditure and is spent both in the public sector on unofficial user fees, or directly with the private sector. Figure 4 shows the situation in selected countries for the year 2002.

Figure 4: Private expenditure on health as % of total health expenditure (2002)[25]



The situation will be worse in fragile states where the state is failing both in its capacity to provide services, and to regulate the private sector. This results in extensive overlap between the public and private sectors, with informal charging, reliance on parallel supplies for key commodities and "moonlighting" by health workers. All of this will disadvantage the poor, who not only will be spending a

[24] Laurence, 2005
[25] Data source: WHO

significant amount of household income on health care, but will usually be getting poor value for their expenditure.

In addition there will be little provision of preventive services, since there is neither incentive for the private sector to provide them, nor effective public provision.

What to do?

Demonstrating some progress in service delivery early on is politically important. Many health reforms in low income countries in the '90s foundered because despite much reorganisation, the benefits were not perceived on the ground. Service delivery is the traditional entry point to work in the health system, and is recommended by DAC as an entry point to broader societal change[26]. It provides a wide scope for short term action, but more sustained work is likely to be frustrated unless there is progress in other areas.

Donors working in fragile states should recognise that the traditional health economy of state finance and provision is being replaced by a more pluralistic system, and should ensure that proposals for building up the health sector reflects this. This does not mean that there is no need to build up the public sector, but to recognise that it will not be a monopoly provider – or indeed the major provider. The sector needs to be developed to meet the needs of what the health economy will look like in ten years' time, not ten years in the past. This will involve taking account of the role of private provision and non-tax finance in preparation of sector strategy and plans.

In post conflict fragile states it will be easier and faster to develop the role of the private sector, and particularly the NGO sector. NGOs may require help in moving from a humanitarian role to a development role, and the emerging Ministry of Health will require help in developing the skills to contract with them for services, and for setting up new schemes (such as franchising and demand side financing initiatives).

If government is "in the driving seat", and particularly if it is the major financer of the health system, it may resent funds going to non governmental and private providers. In Bangladesh the first sector programme included substantial funding intended to be used by Government to finance/commission NGOs – this was never implemented. The obstacles are both technical and ideological, and the MOH may require sustained technical assistance to make this system work.

The traditional way to support service delivery is through subsidy to budget line items, such as salaries and transport. A new strategy, whereby donors provide performance-related supplementary payments, is demonstrating encouraging results. In Rwanda and Afghanistan health facilities (public, NGO or private) receive additional payments in accordance with their rates of delivering certain high priority services (skilled birth attendance, immunisation completion rate, TB detection and cure). The results show significant increases in utilisation for priority conditions, and an apparent decrease in out of pocket expenditure by the target population[27]. However, there are concerns as to how replicable these results are, whether these schemes can operate in the absence of competition, and other issues such as transaction costs and possible perverse incentives.[28]

Where corruption is endemic, donors will have to understand how contracts operate in practice and how best they can be monitored, if an escalation in corruption is to be avoided. Generally the commercial sector has a better understanding of the "rules of the game" than the development sector. Wherever possible, donors should use the expertise of commercial organisations that have been operating in these environments, and have been successful at controlling corruption.

It is also important to be realistic about the capacity and probity of the non governmental sector. While it may seem appealing to bypass government systems and work with NGOs and the for profit private sector, there is no guarantee that these groups will be any more efficient, accountable, or less corrupt. Where corruption is endemic, it is rarely confined to the public sector. Capacity may be particularly limited in community based organisations, and specific capacity building measures may be required if they are to be effectively involved.

[26] 2005b
[27] Soeters 2005
[28] Palmer et al, 2005

Resource development

a) Commodities

The health sector is more reliant on drugs and commodities than other social sectors. When these are imported (as is often the case), the associated requirement for foreign exchange can be a real problem for some governments. Drugs are valuable and tradeable, and lucrative kickbacks are associated with their registration and procurement, so limiting corruption is important. There is a whole raft of issues associated with differential pricing of pharmaceutical products, and concerns about re-importation are likely to be particularly high in fragile states[29]. Furthermore, donors can compound problems by operating in a fragmented way, for example supplying different formulations of drugs, including those not recommended by national policies.

What to do?

Purchasing drugs can be a very good way for donors to spend money. Swiss support to a drugs fund and related systems in Mozambique during the war resulted in increased drug availability, significant cost savings, and laid the foundations for a drug system that continues to be one of the best in Africa, and which is now incorporated into the SWAp[30]. International procurement can result in major cost savings and improvements in drug quality. If donors supply the cash, there are no problems with the shortages of foreign exchange that some countries experience. Provision of drugs or commodities in kind is thought to have less impact on the macroeconomy – which is important where there are high levels of overseas development assistance.

Adequate management capacity is needed to ensure that the right resources get to the point of service delivery. Too often products expire in central warehouses, or health facilities are faced with a surplus of one drug and stock-outs of another. Developing pharmaceutical management capacity should be a long term venture (anything short term will undermine local systems, and then leave a void). It is also important to ensure that the product goes through appropriate national regulation procedures and is compatible with local guidelines.

Social marketing can be an excellent way of spending health resources in difficult environments in a way that has a tangible impact on at least intermediate indicators of health status (such as knowledge and use of condoms or insecticide treated nets). In many ways social marketing fulfils the donors' requirements for effective intervention in fragile states: it has relatively simple, quantifiable inputs and outputs, scope to bypass government systems, and scope to absorb significant resources with minimal administration costs to the donor. However, the most successful social marketing programmes are those dealing in simple commodities, and the scope for extending into the broader health sector remains questionable.

In designing and assessing social marketing programmes, donors need to be careful that their subsidy does not undermine the ordinary private sector distributors, which may be operating in a more efficient, sustainable, and equitable way[31]. The transaction costs of these social marketing programmes may also be very high (giving the product away is frequently cheaper). A review of ITN marketing programmes in Africa revealed that although projects were selling nets with a value of about $4 for about $4, the additional cost to the donors was between $6-$15.[32]

Some very successful social marketing programmes, such as that initiated by PSI in Nigeria, are now managed through a national NGO. This model is very effective, but its replicability in the short term can be limited by the time required to develop the institutional and human capacity within the local organisation. Over a decade of support and mentoring is probably the critical determinant of the success of this programme.

b) Facilities

Facilities are often in a very poor state of repair – either as a result of years of chronic underinvestment, or because of damage during conflict. Whilst an easy way to spend money, facility refurbishment or equipment supply on their own are unlikely to deliver much health gain. Facility building programmes are often more about political patronage and lucrative construction contracts than health needs.

[29] UK working group on increasing access to essential medicines in the developing world DFID 2002
[30] Javier Martinez , personal communication
[31] Webster et al 2005
[32] Jo Lines, personal communication on RBM ITN strategic framework.

What to do?

It is usually more cost effective to refurbish facilities that exist and are being used (or were used in the past) rather than build from scratch. Priorities for refurbishment should be based upon use, and donors should be careful about constructing new public facilities that may undermine or duplicate NGO or private facilities that are working well.

c) Human resources

Management of human resources is a particular problem. It is compounded by the fact that there is a global shortage of health workers, and that terms and conditions are much more favourable in developed countries. Doctors and nurses are particularly mobile, and international migration is a major issue. Once medical staff have left a country (perhaps because of war, or because of their inability to make a living without engaging in corruption) they will be unlikely to return. This poses a huge constraint on reconstruction, and one that will take years and very substantial investment to overcome. Staff remaining in country are likely to be attracted by international agencies and development organisations that offer much more generous salaries, which further undermines government capacity.

What needs to happen?

Actually paying salaries on a regular basis can have a huge impact on motivation and getting health services going again. Donors may not be willing to take on salary payments, but may be prepared to pay incentives. If they do this, it is really important that these are appropriate and co-ordinated, in order to avoid massive distortions in health service provision, and resentment and resistance in other parts of the civil service.

Donors should avoid further undermining government capacity by recruiting their best staff, and should discourage the NGOs they support from doing the same. However, there may be good reasons (political or ethnic for example) why talented staff are not willing or able to work with government. Even in this instance it can be very beneficial if they remain in country (perhaps working with NGOs) and available to resume work within the system if and when there is a change of government.

d) Information

A reliable and timely supply of information is important for effective management, to develop and maintain political interest, and to build effective, informed demand for health care. Cash and capacity strapped governments rarely invest enough in information systems, and this is something that donors can very usefully fund. There are major efficiency and cost savings associated with getting a system that is adequate for all donor purposes, by avoiding replication and encouraging harmonisation[33]. Donor support to monitoring, and to the dissemination of results in an accessible format, can be an effective way of supporting indigenous demand for better levels of service. For example, donor investment in the 2001 HIV sentinel surveillance, and the widespread dissemination of results, was an effective way of ensuring that the new government of Nigeria took HIV seriously.

Financing

Healthcare delivery in fragile states is likely to be compromised by inadequate resources: the total budget is often low, and a small proportion of this is allocated to health. There may be a tension between economists wishing to limit public expenditure and stabilise the macroeconomy, and health specialists wanting to increase expenditure.

Financial management is also likely to be weak, meaning that some money is siphoned off as it flows through the system, and the flow of funds is irregular and unpredictable.

The majority of health expenditure will almost certainly be out of pocket payments. This is unsatisfactory, but there is limited scope for developing effective insurance schemes where capacity and trust are limited, and much of the population is not in formal employment.

Within the health sector there is a particularly wide range of aid instruments and actors. Internationally there are several UN organisations, development banks, global partnerships, bilateral and multilateral agencies, international NGOs and foundations. Most of these agencies operate at country level, where

[33] Lucas and Zabel 2005

there are also other players: national NGOs, the mission sector, and the formal and informal private sector. This offers donors great flexibility, but also presents major challenges around harmonisation and ensuring efficient co-ordinated provision.

What to do?

In most fragile states there is not much point in increasing the proportion of revenue allocated to health, until existing resources are used more efficiently and leakages are contained.

Poor financial management, with the resulting loss of funds and unpredictability of disbursement, is an important issue. Ideally donors should work with governments to address this. However, corrupt governments may be loath to "open their books", and donors may lack legitimacy to deal with the problem, unless it is associated with "on budget support". This is a critical opportunity that should be seized where possible, both as a means towards sustainable change, and as an entry point to broader societal reform.

In reality donors will usually have to resort to their own, parallel systems. In the interests of aid effectiveness, and to avoid fragmentation, donors should pool resources wherever possible, or at least use common systems. They should try to align with government budgetary cycles, and funding along the same administrative lines. Whichever of the many funding channels they elect to use, they should try to ensure that it operates in a harmonised manner.

Donors should pay recurrent costs – acknowledging the risks of fungibility. Ensuring that money gets out to the point of use in timely fashion is critical. Without this, all other approaches are likely to become discredited and founder. Funds should be allocated for long time frames, even if within a flexible framework and subject to regular performance reviews.

Donors should be cautious about enforcing generalised prescriptions for funding mechanisms (e.g. reforming user fees), particularly if there is a functioning system at local level.

Demand, accountability & communications

There is a growing appreciation that what really improves service delivery in a sustainable way is consumer demand for quality health services. Participatory surveys of poor people's priorities always identify health as an issue. Less work has been done on how the articulation of this demand can be supported on a large scale, or in a strategic way. There are particular complexities related to the difficulty of assessing quality in health care (for example, a service that offers multiple drugs, preferably by injection, is perceived by many to be a good one; if it is located in a hospital, it is perceived to be even better.). There are also challenges in ensuring that adequate preventive services are provided, even if there is less expressed demand for them.

In most developing countries, most health care takes place at home. Most children die without being seen by a health professional. This is even more the case in fragile states. Improving the knowledge base of mothers – around basic preventive and curative care, and when to seek help – can have a major impact. Particularly in areas where there is intermittent warfare, formal health services can be only accessible during lulls in the conflict, and this enhanced knowledge may be the only sustained effect of donor interventions.

There is also a tension between the 'political' agenda, which is trying to build expectations and demand for adequate services and accountable provision, and the conventional health promotion agenda that only builds demand for services that are available.

What to do?

Information – particularly when it demonstrates local performance against regional, national or international norms, can be a powerful way to undermine provider complacency and community acceptance of poor standards. Publication of the financial allocations and drugs that are being sent to peripheral levels and facilities is a powerful way to build local accountability.

Governments rarely put much money into information systems. Donor resources to support the systems, and for the analysis and dissemination of results to policy makers and the media can be powerful.

Donors can build capacity within the media, and support mass communication programmes. Access to radios is usually high even in poor communities High quality, entertaining, locally acceptable programmes on health issues can have significant impact on knowledge and actions.

Donors can also support local change agents with information and facilitate their communication so that they can develop a locally owned programme for reform. The impact of such programmes is long term and difficult to monitor, but if working with the right individuals, the benefits can be enormous. In Nigeria, the DFID Change Agent Programme (managed by Professor Lambo, who later became the Minister of Health) was instrumental in developing the capacity of potential reformers, and an agenda and platform for reform.

Professional organisations have a very important role in maintaining quality standards, and have often survived despite years of neglect, and sometimes, as in Nigeria, become very active in broader human rights issues. Support, mentoring and “twinning” with bodies in other countries can all have very significant impact.

6. Conclusions

Over the last four years there has been a huge escalation in discussion and analysis around how to intervene in fragile states. There is an emerging consensus in the international policy arena. Major bilateral donors such as DFID and USAID, as well as the World Bank and DAC have all developed excellent policy statements and principles. The challenge for the next decade is to actually get these implemented and mainstreamed into activity and thinking at country level. This paper has attempted to set out what donors could do for the health sector. While based on country experience, the evidence base is thin, and often based on isolated examples. A future challenge will be to gather information more systematically about what is and is not working in particular contexts.

Much can be done to improve health outcomes in fragile states. There is no "right answer", no blueprint for success. Working on health in fragile states is about the art of balancing conflicting imperatives, and minimising internal inconsistencies. These include the massive agenda for change but minimal capacity to intervene, or the need for partnership, but the little appetite for it, at country level. The right instruments, and the right things to do, have to be decided according to the context.

Whatever approach is developed, donors should avoid undermining what already exists, overwhelming existing capacity or diverting it from more important functions.

It is not the issues or the interventions that are particularly difficult or clever. What does cause problems is prioritisation and implementation. Criticising activities and approaches within fragile states is very easy, and because approaches are almost inevitably suboptimal, there is a great temptation to redesign too frequently. This is particularly unhelpful in a context of limited capacity.

Because of the difficulties in implementation, funding has to be predictable, and for long time frames. Support to recurrent costs is critical (in contrast to donors' current behaviour, which tends to support short term capital projects).

The issues around harmonisation and alignment are also particularly pertinent in fragile states – and the challenges greater. There may not be a country system or strategy with which to align. Donors may have different priorities, staff in country may lack experience and confidence. The quest for an excellent approach can result in fragmentation, with each donor going their own way. Although coherent and sustained support, even for a mediocre plan, is likely to result in the greatest gains, few donors are prepared to compromise and act sufficiently flexibly to ensure that support really is harmonised, and where possible aligned.

Working within fragile states is politically sensitive. Understanding the politics and the priorities of "in country actors" is critical. It requires development agencies to have a much better understanding of risk and of the political context in which they operate. Donors need to be more adept at managing political expectations, and clearer and more consistent about their objectives. As with non fragile states, if they want to change the way that a state works, they will probably have to engage and work with that state, even if the risks are high. The challenges may be greater in fragile states than other less developed countries, but with the exception of a small "hard core" of states, they are not qualitatively different. Major gains can be made both in terms of service delivery, and of catalysing societal and systemic change. Very often these might be attributable to individuals, and specific circumstances, and there will be a significant proportion of interventions that fail to have much impact. Donors need to accept this as a function of working in high risk environments, learn the lessons, and move on. Maybe more than in any other areas of development there is a need to view individual events within long time frames, and broad contexts.

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