



Federal Ministry  
for Economic Cooperation  
and Development

SPECIAL 145

# Observations on Service Delivery in Fragile States and Situations – the German Perspective



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# 1. Introduction

Currently, 26 nations are classified as fragile states with weak governance structures.<sup>1</sup> Most of them belong to the group of the poorest developing countries in the world, with extremely low social and economic indicators. Together, they are home to between 8 and 10% of the world's population, almost 500 million people. With the Paris Declaration on Aid Effectiveness in March 2005, all major bilateral and multilateral donors in the circle of the Organisation for Economic Co-operation and Development (OECD) reaffirmed their determination to step up their commitments in fragile states, and to support institutional development in order to help stabilise such states. The call to “stay engaged but differently” means that cooperation should be upheld even under difficult conditions, or launched or resumed at as early a stage as possible, and that donors should take a preventive approach. The need to secure supplies of basic services for the entire population and the necessity of ensuring access for all by promoting basic social services both play a central role in the discussion.

This synthesis report follows on from two international working processes which looked at these problems and in which the German Federal Ministry for Economic Cooperation and Development (BMZ) played an active part, and summarises the most important results and conclusions.

## OECD/DAC Working Group on “Service Delivery in Fragile States”

The main outcome of the Senior Level Forum on Development Effectiveness in Fragile States,

which was held in January 2005 in London, was the formulation of the Draft Principles for Good International Engagement in Fragile States. This process is being coordinated by the Fragile States Group (FSG) of the OECD/Development Assistance Committee (DAC). At present the principles are being tested, and are scheduled to be adopted at the High-Level Meeting in 2007.

The FSG has also set up working groups to consider other important issues. These aimed at producing guidance papers on the pertinent areas which will be adopted at the OECD/DAC level.

BMZ has played a key part in shaping the work of the working group dealing with Service Delivery in Fragile States.<sup>2</sup> The responsible division at BMZ (Division Governance, Democracy, Human Rights, Gender) worked closely with Divisions 311 (Education; Health; Population Policy), 313 (Water; Energy; Urban Development) and 210 (Peace-building and Crisis Prevention; Foreign and Security Policy; Research; Selected Policy Issues), in tandem with the relevant country divisions. The German contribution was further elaborated with the help of the project on “Promotion of Democracy and Good Governance” implemented by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

German Development Cooperation (DC) was involved in two phases. The first phase consisted of collecting methodological contributions in order to facilitate the overall steering of the working group. During the second phase, conceptual

<sup>1</sup> On the basis of its assessment instrument, the Country Policy and Institutional Assessment (CPIA), in 2006 the World Bank classed 26 states as “fragile” (i.e. core and severe low income countries under stress). The CPIA looks at the following indicators: economic management, structural policy, policy for social inclusion and justice, public sector management and institutions. Source: [http://www.worldbank.org/ieg/licus/licus06\\_map.html](http://www.worldbank.org/ieg/licus/licus06_map.html).

<sup>2</sup> Two other working groups have been set up to examine the issues of “Whole of Government Approaches” and “Aid Flows”.

inputs were produced for the health and water sectors.

This synthesis report documents lessons learned and conclusions drawn within the scope of the second phase. These are based largely on the results of five country studies, two conducted in the water sector (Eritrea, Yemen) and three in the health sector (Côte d'Ivoire, Guatemala and Nepal).<sup>3</sup> At the same time, numerous interviews were conducted with German development experts, focusing on the following issues: development orientation and governance in the respective partner countries, policy steering and regulatory tasks, social service systems (health and water), the utilisation of these services by the population, the influence of civil society, the concepts and results of German DC, and the presence of and cooperation with other donors.

#### **Working group on fragile states within the framework of the Education for All Fast Track Initiative (EFA-FTI)**

A working group on fragile states has been set up within the framework of the Education for All Fast Track Initiative (EFA-FTI). Because of the German

support given to the FTI, coupled with the fact that in 2007 Germany will co-chair the initiative as holder of the G8 presidency, the project on "Education and Conflict Transformation", implemented by GTZ, is working intensively on this topic, with special emphasis on capacity development.

#### **Observations on Service Delivery in Fragile Situations**

The various lessons learned by German DC have been discussed and compiled at several workshops held at BMZ as a contribution to the international processes. The workshops were attended by representatives of the BMZ and GTZ sectoral and regional divisions, as well as by representatives of the German Development Service (DED), the Working Group on Development and Peace (FriEnt) and the German Institute for Human Rights.

This synthesis report is structured as follows: Chapter 2 contains a summary of observations and key statements of German DC that pertain to service provision in fragile states, followed by the summarised versions of the country reports in Chapters 3-7.

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<sup>3</sup> The country studies are based on the analysis of files and the literature as well as numerous structured interviews with experts and key actors in Germany and in partner countries. Within the framework of the three studies in the health sector, official journeys were also made to the partner countries.

## 2. Observations on Service Delivery in Fragile States and Situations – the German Perspective

Health, education, drinking water and basic sanitation are not just aspects of social services, but rather universal human rights **which have to be progressively guaranteed by the state**. Fragile situations generally correlate with higher levels of poverty and more significant gender inequalities.

As such, all these services must not only be available and of adequate quality, but also culturally acceptable and in particular accessible to all children, women and men alike – in any country and for all population groups. In ensuring accessibility, service delivery needs to take into account the gender, age and ethnicity of the beneficiaries. In fragile situations and in instances of bad governance, human rights are frequently violated, and the principles of non-discrimination and equality of opportunities, transparency and accountability, participation and empowerment are often neglected.

**The challenge for development cooperation is to find ways to contribute to the transformation of both state fragility and bad governance by appropriately using strategies and instruments.** Political will in particular determines the extent to which donors can engage directly with the state and its institutions. If partnerships with governments are difficult, donors may have to deepen their cooperation with the civil society and the private sector. Even in these cases, donors should simultaneously seek to establish entry points within the government, in line with the long-term goal of state building.

### 2.1 Engaging in social sectors and service delivery

2.1.1 When selecting instruments, special attention should be paid to the following aspects:

- The **living conditions** of the poor and the **human rights situation** should improve or at least not deteriorate;
- Appropriate funding and cooperation instruments must be **used transparently, protected against misuse** and not be hijacked by those in power to **stabilise or legitimise bad government performance**;
- The instrument(s) selected should **contribute to political transformation** and promote good governance.

2.1.2 **Vulnerable and marginalised groups** need special attention as the beneficiaries of services. These groups are **rights-holders as well as important actors** for service delivery in fragile states. Insights from the education sector, for example, show the significant benefits that can accrue from the inclusion of youth in planning and the implementation of development activities in conflict settings.

2.1.3 In fragile situations, the political will of the government and other political key actors to promote development **is also key for successful cooperation**. Often, there are overriding interests that must be addressed. Accordingly, **approaches to service delivery should distinguish between partner**

**structures that are development-oriented, transparent and accountable, and those that show significant deficits.** These factors are crucial and determine the selection of strategies, partners and instruments.

The case study on water service delivery in Eritrea exemplifies these dilemmas.

- 2.1.4 Improvements in governance, including opportunities for democratic participation, are vital when it comes to improving service delivery.** The state's ability to ensure the provision of social services to its citizens will be severely hampered if there is a lack of responsiveness, accountability, legitimacy and social coherence. However, **improvements in service delivery can increase the legitimacy of a government and can thus have a positive impact on the other dimensions of fragility.**
- 2.1.5** There is a significant overlap between fragile states and conflict-affected states. Violent conflict can aggravate state fragility, and wars often erupt when state functions and human rights obligations are not adequately fulfilled. It is therefore important that **all interventions should be conflict-sensitive and should contribute, as much as possible, to non-violent conflict management and peace building.** Furthermore, the existing data and instruments for conflict-sensitive development planning and implementation should be taken into account and utilised.
- 2.1.6 The degree of a country's fragility alone does not provide a sufficient entry point for intervention, but analysing its root causes and the quality of governance does.** Thus, for programming purposes, the categorisation of **state fragility** should be based on a situational analysis that identifies the specific context. Important root causes of state fragility include marginali-
- sation, disempowerment and discrimination of population groups, often complemented by the state's lack of political will or limited capacity to improve social service delivery to the people. At the same time, *drivers of change analysis* need to be identified for effective interventions: **it is essential to discover which actors have a genuine interest in reforms, and then to strengthen them.**
- 2.1.7 State/institution building needs to take a country's unique governance system features and degree of fragility as a starting point.** State structures may have deteriorated, or they may never even have existed. In addition, formal governance systems often coexist with traditional and/or other informal ones. Thus, state building needs to build on the existing structures without losing sight of the key principles of governance and human rights. In addition, the process needs to focus on strengthening both central and local structures. As the case study on Yemen shows, service delivery does not have to suffer from strong regional political identities.
- 2.1.8 In a fragile environment with weak institutional capacities and inadequate political leadership, international cooperation can still build "islands of excellence" at the local level.** Even though limited in geographic scope, they can and should have an impact in terms of providing a positive role model in governance through improved service delivery and advisory services. It is important, however, to build and strengthen links between the local, regional and national levels in order to contribute to state building. **For service delivery to be sustainable, parallel structures must be avoided in the long run by aiming at effective collaboration between the state and non-state providers.**

- 2.1.9 Support for demand-oriented services contributes to the empowerment of citizens.** This is important in terms of ensuring the accountability of service delivery, particularly given the failings of state institutions in this respect. Thus, the civil society should participate in the formulation and implementation of sector strategies and in the delivery of services. This approach works best where services closely interact with the local population, enabling them to build on local knowledge and needs and to include traditional authorities and structures. In the case of cooperation with non-governmental organisations (NGOs) and community-based organisations (CBOs), it has to be ensured that these work in a socially inclusive and non-discriminatory fashion.
- 2.1.10 Depending on the type and nature of fragility, basic services such as health and water can be widely accepted entry points for donor engagement.** This is even true for conflict situations, where the strong demand for health services in particular leads to donors being more easily accepted by conflict parties, opening a window of opportunity for a very early engagement. Under such conditions, donors are more accepted when they are perceived to be impartial, as the case study on health service delivery in Nepal demonstrates.
- 2.1.11 Fragile structures are not confined to fragile states alone, but can also be found in countries that are generally more stable.** Therefore, the principles for good engagement in fragile states may also be applied to other developing partner countries that have pockets of exclusion (marginalisation of indigenous populations, refugees/internally displaced persons etc.).
- 2.1.12 If long-term stabilisation and development are to prevail, the service sector of education is of the utmost importance.** Education can contribute positively to turning around a country. Since education is not normally part of humanitarian aid packages, there can be no transition from humanitarian to development-oriented approaches. Instead, education systems often have to be rebuilt from zero. This is sometimes literally the case, as education facilities are regularly soft targets for the military, as they are perceived as representatives of the disputed government's authority.
- 2.2 Improving aid structures**
- 2.2.1 Donors need to use political dialogue to build political leadership, ownership and commitment** in order to ensure adequate emphasis on social sector spending in the recipient government's budget. They also need to ensure adequate technical assistance to **build state structures/institutions**. In terms of service delivery, such structures will foster effective, demand-oriented services that are accessible to poor and vulnerable populations.
- 2.2.2 Donors need to consider adjustments to their internal structures.** This includes decentralising their structures and ensuring a higher degree of flexibility in the mix or sequencing of aid instruments and of monitoring and evaluation (M&E) procedures. In addition, innovative financing instruments for more flexible responses and rapid disbursement mechanisms need to be created, such as the combination of bilateral and regional funds or the establishment of budget support instruments for fragile states or states in transition, and the systematic use of multilateral instru-

ments. Furthermore, it has to be accepted that development cooperation in fragile states is – for reasons of security, volatility and infrastructure – more expensive than in comparatively stable settings.

**2.2.3 Donors need to ensure that international responses to humanitarian crisis are effective and consistent with the “Principles of Good Humanitarian Donorship”.**

**At the same time their security and development programmes must be harmonised and interconnected in terms of their strategic direction.** Even during conflict and early post-conflict engagement, support simultaneously needs to lay the ground for long-term state and institution building. Donors also need to avoid financial gaps as countries move from one support programme to the next. This can be achieved by creating intermediate basket funding lines or multi-donor trust funds, provided that the recipient country’s government is willing to reform and to set up transparent and accountable financial systems. Here, two other aspects are decisive. **Firstly, this financial support needs to be accompanied by sector reforms and effective capacity development, e.g. through technical cooperation. Secondly, parallel structures should, in the interests of sustainability, be avoided.**

**2.2.4 Engagement in service delivery needs to be based on a long-term perspective.**

**The time needed to build legitimate and efficient service delivery structures is likely to be longer than in more stable countries and donors need to be prepared for possible setbacks and periods of stalemate.** Their support strategies should thus not be subject to periodic policy changes. Staying engaged in difficult periods also has a considerable trust-building effect. Long-term donor engagement requires

long-term presence of qualified staff on the ground in order to provide the necessary support and advice for policy formulation and implementation processes, as well as to enhance donor coordination. Different approaches to staying engaged can be gathered from the case study on health service delivery in Côte d’Ivoire, for example.

**2.2.5** Especially in resource-poor conditions and in instances where standard services are neither culturally acceptable nor accessible to all social/ethnic groups, **local and traditional expertise should be supported** as a locally owned and readily available resource. For instance, the case study on health service delivery in Guatemala provides several examples of this underutilised potential.

**2.3 Issues of harmonisation and alignment**

**2.3.1 The weaker and the more fragile government structures are, the more important it becomes to ensure harmonised, coordinated and coherent engagement of donors with the recipient country.**

Enhanced donor coordination mechanisms at the country and global levels remove additional strains from the partner government. Donors may, as required, assume interim stewardship functions in terms of donor coordination in the absence of national capacity. In such cases, handing-back mechanisms need to be included from the design stage. In conflict situations, a harmonised donor approach also makes local engagement safer, more transparent and more effective. The Basic Operating Guidelines in Nepal (see the case study) are an internationally recognised example of harmonisation in a conflict setting.

- 2.3.2 Alignment of international support to the recipient country's structures is essential. Aligning to a common development agenda can provide the recipient country's government with a positive model of donor behaviour, and may enhance the prospects of a compact for mutual accountability.** The agenda should preferably be based on the development framework of the partner country (built with the active participation of the civil society), or alternatively on a mutually agreed pro-poor development agenda. As far as possible, the approaches used should also include **incentives for governments to improve their performance** as part of the strategy.
- 2.3.3 Donors should address the public financial management systems of the recipient country.** Partner countries need to ensure that these systems allocate an adequate share of funding to social services. In general, basic reforms of public financial management are needed to produce **visible improvements in their public financing systems.**
- 2.3.4** Budget support instruments may be an option for governments **willing to reform, provided that the minimum criteria for solid and transparent financial management are defined. The first-choice instruments are multilateral trust funds or basket funds which restrain fiduciary risks.** In countries with governments that are not reform-oriented, donors can channel their support through NGOs or local or regional level institutions.
- 2.3.5** Many aspects of service delivery in fragile states naturally depend on issues far beyond the reach of development policy. Trade policy, for example, defines the availability of imported commodities in a fragile state. Accordingly, **whole-of-government approaches should be adopted wherever possible.**

## 3. Eritrea Case Study<sup>4</sup>

### Workstream on service delivery – water and sanitation sub-group (WATSAN)

#### 3.1 Introduction

Eritrea is one of the poorest countries in the world, with a GDP per capita of US\$ 849 (PPP – purchasing power parity) in 2003 and a Human Development Index ranking of 161 out of 177 countries. It has a population of 4.1 million, of which more than 50% lives below the national poverty line. Eritrea is deeply marked by the still unsettled conflict with Ethiopia and continues to face a large number of unresolved post-conflict challenges.

On the economic front, the war between Ethiopia and Eritrea from 1998 to 2000 has severely damaged the country's economy. Although in 2003 the economy seemed to have initially recovered, recording a growth rate of 3%, the country was recently hit by one of the worst droughts in more than a decade, which caused growth to fall again to 1.8% in 2004.

#### 3.2 The nature of fragility in Eritrea

It should be pointed out that Eritrea does not feature very prominently in the debate on state failure – indeed, in the recently published “Failed States Index” for example, Eritrea is only ranked 55th out of a total of 60 listed countries. However, despite the fact that the country is not classified as an example of the most extreme scenario (i.e. full collapse), there are nonetheless good reasons for including Eritrea among the group of fragile states. State fragility in Eritrea must first of all be placed into historical context. Eritrea is the youngest of

all African states, only gaining independence in 1993, after more than 30 years of fighting a war of liberation against Ethiopia. The unsettled conflict with Ethiopia is the major source of fragility, as its consequences still largely determine the country's general framework for development.

By the end of 2005, tensions between Eritrea and Ethiopia had once again escalated to such a point that observers feared the outbreak of a new war. In this context, the Eritrean government believes that it needs to maintain the country in a state of emergency and a high level of military mobilisation.

For this reason, large parts of the country's financial, material and human resources continue to be allocated to the military sector, with the unavoidable corollary that all other sectors suffer from shortages of much needed resources.

The Eritrean Transitional National Assembly accepted the principle of political pluralism in 2002, but declined to pass a law on political parties, which leaves the ruling party (the PFDJ) as still the only legal political grouping. In practice, this means continued reliance on informal lines of communication and ad hoc decision-making, with few written policy statements or fixed government responsibilities. On top of this, there are extreme capacity deficits with respect to national ministries, commissions and authorities.

#### 3.3 The Eritrean water sector

Eritrea has a predominantly arid to semi-arid climate. While annual rainfall ranges considerably, from less than 50 mm to more than 1,000 mm, over

<sup>4</sup> This case study was compiled by Stefan Lindemann of the Environmental Policy Research Centre (ffu) of the Freie Universität Berlin.

90% of the total area receives less than 450 mm. Rainfall in Eritrea is torrential, of high intensity and short duration, and varies greatly from year to year. Despite the unreliability of precipitation, however, most of the population in rural Eritrea depend on rain-fed agriculture for their livelihood.

The country is generally poorly endowed in terms of water resources. Even though the country's water resources have not been thoroughly assessed, actual renewable water resources (km<sup>3</sup>/year) were estimated at just 6 km<sup>3</sup> in 2000, which amounts to a per capita water availability of 1,466 m<sup>3</sup>/person/year (see Table 1). This is a very low figure even in sub-Saharan Africa, where levels of per capita water availability average 6,322 m<sup>3</sup>/person/year.

### **Water supply and sanitation**

While 72% of the urban population has access to improved drinking water, this is only the case for 54% of the rural population. Coverage rates do appear to have improved since 1990 (up from 40% in 1990 to 57% in 2002), but almost half of the population continue to rely on "unsafe" sources of drinking water such as unprotected public wells, springs, rivers or tankers. The quality of the existing drinking water generally gives rise to concern. Bacteriological contamination is a very common phenomenon, as many water points are not protected or are insufficiently far from potential sources of pollution.

The access to improved sanitation is even more problematic. At 9%, the Eritrean sanitation coverage rate is among the lowest in the world, and far below the sub-Saharan average in both urban and rural areas. While 34% of the urban population has access to improved sanitation services, this is only the case for 3% of the rural population – the third-lowest rural coverage rate in the world.

### **Water institutions and policy development**

Since independence, the Eritrean water sector has been subject to a prolonged process of insti-

tutional and organisational (re)organisation. Organisational responsibilities have shifted several times in recent years, and the reform process is still far from being achieved, as the existence of numerous draft documents that remain to be adopted clearly shows.

Several governmental organisations are responsible for aspects of the water sector, the major ones being the Ministry for National Development (MoND), the Ministry of Land, Water and Environment (MoLWE), the Ministry of Health (MoH) and the Ministry of Agriculture (MoA). The MoND enjoys the status of a "super ministry" that oversees the development plans of the whole country and coordinates all sectoral activities of the line ministries. While it logically has the final say, formal sectoral responsibility lies with the MoLWE, which has under its umbrella the Water Resources Department (WRD) – the main body in terms of Eritrean water policy and legislation.

At present, however, the WRD is handicapped by the absence of a legal mandate to exercise its responsibilities, insufficient technical infrastructure and a quantitative and qualitative lack of human resources. It is therefore unable to fulfil its designated functions, and thus the assessment, planning and management of the country's water resources remains fragmented and incomplete.

In the light of these striking deficits, the Eritrean government has since 2003 displayed increasing political willingness to tackle existing problems in the water sector. The government, in common with water professionals in various water-related institutions, is fully aware of the existing shortcomings, and there seems to be a growing consensus that water is a crucial resource for the future development of the country. Nevertheless, Eritrea still lacks a coherent water policy. The Draft National Water Policy Framework of 1997 has never been officially adopted, although a new draft Water Policy Paper was elaborated in August 2004.

The majority of the current shortcomings in the country's water sector can be directly related to the enduring fragility of the Eritrean state, a situation that has prompted the government to continue to allocate the bulk of Eritrea's financial, material and human resources to the military sector. As a consequence, the water sector suffers from shortages of much needed financial, material and human resources. The poorest water users – in particular women – are most affected by the persistent deficits in the water sector, as they continue to rely on unsafe and often expensive sources of water.

### 3.4 The role of international development partners

In terms of its relationship with foreign donors, Eritrea is certainly an unusual, if not unique, case. The country has its own development concept based on objectives that are prioritised and sequenced against a long-term timeframe. The ultimate goal is to modernise the country through a process of “social engineering” (a term that clearly captures the still underlying socialist emphasis).

As a result, the country has a “take it or leave it” attitude vis-à-vis foreign donors, which are welcome to support projects that have received the government's approval, but whose own propositions for involvement in different sectors carry little weight, if any. Eritrea does not want simply to import institutions and solutions from outside, but seeks to develop these based on local experience and concepts following a “slow process of trial and error”.

The Eritrean stance is a relatively novel experience for German development agencies and takes some effort to get used to. While some actors recognise the government's commitment, many still have reservations. Aside from the *a priori* restricted scope of their activities, what concerns German DC the most is the relative lack of com-

munication from the Eritrean government with respect to water policies, the relative lack of predictability of their operations and the consequent difficulties that this entails for budgeting and planning development projects.

### 3.5 German support to the Eritrean water sector

The German government supports the Eritrean water sector with a number of different development projects through German Technical Cooperation (GTZ) and the KfW Bankengruppe (KfW, German Financial Cooperation).

German Technical Cooperation is currently supporting the Eritrean water sector with a €5.1 million project entitled “Rehabilitation of Water Supply Systems in Western Eritrea” (RWSS). Beyond the infrastructure component, the project places strong emphasis on the provision of technical advice to regional/municipal authorities and its Water Supply Services (WSS), with a view to improving the legal, organisational and financial framework conditions, and leading to the creation of autonomous, accountable and cost-covering water service units.

German Financial Cooperation is supporting the Eritrean water sector with two different development projects: a €17.4 million project that funds urban water supply and sanitation measures in Massawa and a €5.0 million project that seeks to improve the rural drinking water supply in the Gash Barka. The latter project has a clear poverty focus and aims at supplying the rural population with qualitatively safe drinking water at acceptable prices.

The German approach has been described as “extended emergency relief”, as it focuses on largely technical aspects and is strongly oriented towards the target groups. Donor intervention in the field of the institutional structures of water

supply is regarded as politically more sensitive and thus meets more resistance.

Beyond German DC, there are also a few other international donor organisations that are working to support the Eritrean water sector. These include a number of UN organisations (UNICEF, the UNHCR, the WHO and the UNDP<sup>5</sup>), the European Union/Commission (EU/EC), France, the Japan International Cooperation Agency (JICA) and several others. Overall donor coordination remains largely limited to the geographical distribution of projects, plus occasional informal talks at the bilateral level.

### 3.6 Lessons learned and recommendations

The post-conflict recovery of Eritrea is hindered by the enduring state of emergency and military mobilisation owing to the unresolved conflict with Ethiopia. This situation of persistent fragility monopolises the agenda of the Eritrean Government, and has very negative implications for the Eritrean water sector.

Bearing in mind the “OECD Principles for Good International Engagement in Fragile States”, the lessons learned from the German engagement in Eritrea can be summarised as follows:

- Take context as a starting point. The Eritrean case underlines the need to calibrate analysis and action to particular country circumstances.
- Face the need to deal with difficult governments. The experience gained in Eritrea draws attention to the fact that donors may have no choice but to engage with difficult governments in one way or another.
- Remain pragmatic. In a fragile environment like that of Eritrea, it may be both more pragmatic and promising to go ahead with implementation and prioritise the strengthening of the municipalities and the existing water supply services, while working towards a more long-term vision for the elaboration of a sound sectoral framework.
- Be ambitious and focus on state building. Despite the technical focus, GTZ and KfW carefully integrate into their infrastructure projects political measures aimed at moving towards a more sustainable water sector policy.
- Sequence aid and find entry points. The German involvement in Eritrea underlines the possibility of gradually providing “extended emergency relief”. While the water projects were initially largely relief-oriented, they were complemented by small dosages of political conditionalities meant to find entry points whereby water policy development could be influenced.
- Be patient, stay engaged, and give success a chance. German DC in the Eritrean water sector has not yet achieved all the envisaged results. This should hardly come as a surprise, since donor involvement in an enduringly fragile post-conflict transition country like Eritrea requires a lot of patience, a willingness to compromise, and the readiness for continued political dialogue that is based on a long-term vision for the country.
- Improve coordination among international actors. In as politically difficult an environment as that of Eritrea, the coherence and coordination of international development assistance can hardly be rated too highly.

<sup>5</sup> The United Nations Children’s Fund, the United Nations High Commissioner for Refugees, the World Health Organization and the United Nations Development Programme, respectively.

## 4. Côte d'Ivoire Case Study<sup>6</sup>

### Workstream on service delivery – health subgroup

#### 4.1 Introduction

On 19 September 2002 civil war broke out in Côte d'Ivoire (CIV) and the northern part of the country was seized by Muslim rebels calling themselves the "New Forces".

In January 2003, President Gbagbo and rebel leaders signed accords creating a government of national unity. However, the main problems remained unsolved and neither side has been able to gain control over the whole country. Since then the so-called government of unity has proven extremely unstable. In March 2004, 120 people were killed in an opposition rally. A later report concluded the killings were planned. Though UN peacekeepers were deployed, relations between the president and the opposition continued to deteriorate.

A new presidential election was supposed to be held in October 2005, but delays in the preparations for this led to it being postponed until October 2006. Due to pressure from the African Union (AU), both sides agreed that the former president of the West African Central Bank, Charles Konan Benny, would become the CIV's new interim president.

#### 4.2 The nature of fragility in Côte d'Ivoire

The main reason for CIV's crisis is the ongoing political rivalry among all protagonists, who use questions of nationality and resources to manipulate public opinion. The current government of

national unity comprises 41 ministries, which vary in their financial and personnel capacities. Based on the huge power exercised by the president and his ethnic group, planning and progress at ministerial level is difficult or even impossible, and the will to achieve political reform is very limited. Development cooperation founded on the principles of participation and national "ownership" has only recently become possible, and then only to a limited extent.

A typical aspect of the fragility in Côte d'Ivoire is that the civil war predominantly affects the northern parts of the country, whereas most southern parts have hardly suffered. The central government commands no authority over the north. Nevertheless, the country has remained a *de jure* unified state, largely owing to its relatively stable economy. Even during the crisis, CIV remained the world's largest exporter of cocoa (around 40% of the world production) and the third largest exporter of coffee. Compared to other countries in the region, CIV has an above-average GNP of US\$ 770 per capita.

The fragility of the Ivorian state in terms of health is most starkly illustrated by the near breakdown of the northern health service sector.

#### 4.3 The health sector in Côte d'Ivoire

##### National health policy

In 1996, CIV adopted a national health programme as a planning framework for the period 1996-2005 (Programme National de Développement Sanitaire - PNDS). The PNDS aims to:

<sup>6</sup> The study was compiled by Katja Schemmann, GTZ, Division Governance and Democracy.

- improve health services (distribution, quality and use), particularly basic health services;
- increase the vaccination rate for children from 60% (1996) to 80% (2000);
- control AIDS;
- reduce the average fertility rate from 5.7 in 1994 to 4.5 in 2015;
- disseminate modern contraceptive methods.

The PNDS embodies the political will of attaching high priority to improving health care services. When the Gbagbo government came to power in 2000, it even envisaged building a general health insurance system to enhance access to public health services for the poor population. However, ever since the political unrest began in 2002, health service provision has not enjoyed the same priority, and the health programme has since then effectively been suspended.

### HIV/AIDS

With an estimated average HIV/AIDS prevalence between 7 and 9%, CIV is one of the countries in West Africa hardest hit by the spread of the virus.<sup>7</sup> In response, AIDS control has been given high priority, and in 2001 the government adopted a national AIDS control strategy.

### Structure of the health care system

The MoH is at the top of the health system pyramid in CIV. Besides this, there is also a ministry for HIV/AIDS control. The two ministries are responsible for planning, regulatory and control tasks. However, neither performs its management functions adequately. Some formal regulatory mechanisms do exist, for example regarding physicians

establishing practices, but these are not applied in practice. In addition, policymakers do not perform their regulatory and control functions. This is partly due to their restricted control over national territory or other government priorities, and the resultant lack of funding. For the most part, there are no sanctioning mechanisms for failure to provide health services or for their inadequate delivery.

Citizens have little or no means of influencing policymakers because of the lack of policy decisions, the lack of transparency, the absence of mechanisms for civic participation in policymaking and the inadequate organisation of the population with regard to claiming their participation rights.

Users exert no influence on the delivery of health services by providers. Moreover, control instruments are lacking, and the low level of organisation prevents them from exercising any control over the providers or from influencing services. There is seldom any choice of health service provider, particularly in rural areas.

The majority of health service providers are in the governmental sector, with only a few denominational or NGO-operated health facilities. These providers are held in very high esteem by the population, as they render good services, often free of charge. Private providers are not an option for the majority of the population as they are too costly. Traditional medicine plays a significant role, particularly in rural areas. The main reasons for this are easy accessibility and favourable costs but also a high degree of credibility.

### Decentralisation

The decentralisation of health care has been the declared reform policy of many of CIV's international development partners for several years, the

<sup>7</sup> Source: UNAIDS, 2004.

aim being to improve the parameters for local level health care and to involve private and NGO service providers.

After various phases of decentralisation since 1985, CIV has now been subdivided into five different types of local/regional administrative bodies. Decentralisation has made more rapid and far-reaching progress in the health sector than in other areas, particularly in the construction, administration and equipping of health centres.

### **Disparities in health care**

The geographical distribution of health service providers in CIV is uneven. Even before the crisis, the available services and infrastructure in the north, southwest and northeast were inferior to those in other regions. The crisis has moreover widened such regional disparities. In the north and west of the country, very few public services are provided. Schools and hospitals in particular suffer from a lack of personnel and equipment. Owing to the crisis, many health personnel have moved to the south and to Abidjan, further exacerbating the widening urban-rural gap (for example, between approximately 60 and 70% of physicians are now based in and around Abidjan). This is largely due to the fact that qualified personnel are not prepared to work under difficult conditions (e.g. no infrastructure or electricity, inadequate medical equipment, few beds, insecurity, or a lack of social infrastructure such as schools) in rural areas.

### **Widespread corruption**

Corruption is rife in the health sector, affecting health services throughout the health system (e.g. overcharging for treatment and medication, cases of fraud with misdiagnoses, embezzlement and the resale of medicines by medical personnel etc.). Alongside shortfalls in the infrastructure and administration (e.g. gaps in patient registration), corruption is a core problem of the health sector.

### **Civil cohesion**

Civil society activities in the health sector are confined almost solely to AIDS control. Altogether, civil society is poorly organised, or partly functions on behalf of political interests. It was repeatedly pointed out during the country study that NGOs do not have a long tradition in CIV. The study was unable to identify any other groups promoting improvement in the health services (except for AIDS control) or advocating a reduction in fees, and in some cases their existence was explicitly denied.

### **The impact of conflict on the health sector**

Generally, service delivery in health suffers from the overall weak governance system in CIV, as highlighted by the lack of transparency, the absence of regulatory and control functions, a lack of mechanisms for civic participation in policymaking, and the inadequate organisation of the population with regard to claiming their participation rights.

In addition, the political crisis has caused the public health sector to disintegrate. While the system in the south has not been affected and continues to function, public health services in the north were closed after the southern-based government lost its authority over and access to these areas, thereby putting the life of its health workers in danger. This left a considerable gap in terms of available health services that has provisionally been filled by traditional service providers and international humanitarian NGOs.

It appears that due to the high expectations of the population, the conflicting parties accord a higher priority to health than to other sectors. More recently, the rebels have even started to reconstruct social services in health education on their own, in particular in response to demands and expectations expressed by the population.

#### 4.4 The role of international development partners

Since the period of severe crisis started, only two partners have continued to provide bilateral development cooperation: Germany, through the GTZ Office in Abidjan, and the European Commission (EC). All other bilateral donors have closed their offices and are merely represented by their embassies. Thus, the fragile governance structure has increasingly shifted CIV towards the status of aid orphan. Under these circumstances, donor coordination processes at the country level are of little relevance.

##### German support to the health sector

Germany classifies CIV as a partner country, with sustainable economic development as its priority sector. Owing to the deadlocked peace process (“not war and not peace”), the scope for development cooperation is restricted, although BMZ has attempted to maintain a presence and keep a political dialogue going to the maximum extent possible. In response to the unstable security situation, German staff were required to leave the country in 2002, and the projects were then coordinated from outside the country. Nevertheless, it proved possible to offer continued project implementation, as German DC projects were operating in areas that were either little affected by the unrest or not at all.

German Technical Cooperation has been active in the Ivorian health service since 1995. The “Assistance to the Health Sector and Family Planning” project was followed in 1997 by the “Promotion of Maintenance in the Public Health System” project, and in 1999 by the “Promotion of the District Health System in Bouaké and Yamoussoukro” project, combining technical and financial cooperation. Originally, the latter project was expected to last from October 2002 until July 2005; this was later extended until December 2006. Since health is not a priority sector for German cooperation with CIV, no further programmes are planned,

except for AIDS control, which will be handled solely as a cross-sectoral theme.

The current project supports the AIDS ministry, the MoH, private health service providers and medical technology companies in developing and implementing promising forms of cooperation. It was in this context that the GTZ HIV/AIDS workplace programme was introduced. This comprises three components: prevention (distribution of contraceptives, education of personnel), health care (HIV tests, therapeutic services and treatment of side-effects) and M&E.

KfW is implementing a social marketing project together with the Ivorian NGO AIMAS (Agence Ivoirienne de Marketing Social). Project measures include the distribution of contraceptives (between 31 and 32 million condoms annually), combined with educational and publicity measures, as well as the implementation of market research studies.

In May 2004, GTZ again seconded a Country Director to Abidjan. The director is the only expatriate staff member, and bears responsibility for all ongoing projects. The projects themselves are conducted by national personnel with support from short-term experts and GTZ Head Office.

#### 4.5 Lessons learned and recommendations

The continued political rivalry has locked CIV at its current level of development. Meanwhile, the possibility of armed conflict continues to loom. This rivalry, combined with high levels of corruption and the lack of political will to reform, have caused health services as a whole to deteriorate rapidly, despite the country’s relatively stable economic situation. For donors, the challenge has been how to deal with a country with limited legitimacy and still continue their engagement. As the case of CIV shows, sectoral advisory services – in this case in the health sector – are basically feasible in fragile states. Nevertheless, not all

project types would appear to be equally viable operationally or likely to achieve results despite the overall situation of fragility.

Developing health care systems in fragile states is a long-term, politically complex as well as technical process. Programmes with a narrower technical and sector-specific focus seem generally better suited as entry points and can help pave the way for broader assistance to government capacities at a later date. In states where governments are either incapable of governing effectively or barely able to do so, entering into cooperation via the private sector or NGOs would seem to make sense. The German health programme's cooperation with business enterprises in CIV is a good example of this.

A functional health service depends on various factors that lie outside the health sector and thus require additional interventions.

Health service delivery in crisis areas faces special challenges. For example, the infrastructure is often unavailable in these areas, the equipment in medical facilities is unsatisfactory and transporting medicine and equipment is costly and frequently dangerous as well. It is, moreover, hard to recruit medical personnel in these areas. In crisis areas, it is essential to establish a secure environment for providing health services for personnel as well as patients.

Strengthening self-organisation in civil society is a good way to begin improving the health service. As long as clients do not demand an improvement in health services, the government and providers see no need to do anything.

The provision of health services can have a stabilising and peace-building effect provided the services are made accessible to all conflict parties alike (the principle of "do no harm"). Particularly in rural areas, physicians (and even nurses) are regarded as persons in authority who deserve

respect. This holds regardless of ethnic allegiance. Even in a difficult climate, development cooperation can find entry points for cooperation with government actors, an observation that leads to the following recommendations:

- To secure long-term stability, focus on themes that can be addressed together with governmental and non-governmental actors (i.e. civil society and the private sector), such as AIDS control.
- Take into consideration the fact that strengthening the civil society and increasing its involvement in decision-making processes can contribute to improved social cohesion.
- Begin with technical questions instead of policy, and promote approaches at the local and regional levels. When political life comes to a standstill at the national level due to fragility, cooperation mechanisms can often be found at sub-national levels.
- Over time, focus increasingly on policies and widen the approaches used to the national level.
- As trained personnel and efficient institutions contribute to sustainable development even in times of crisis, make capacity development, as much as possible, the main objective of external support.
- Support national priorities and donor coordination: in fragile states, it is particularly important for donors to promote national policies and priorities instead of their own. As donor commitment can quickly end up being focused on just a few policy fields (e.g. AIDS control), effective donor coordination is important.
- Cooperate with the private sector: in countries with strong economies, more coopera-

tion with the private sector is an option. AIDS control or malaria prophylaxis are areas that can be of interest to the private sector.

- Stay engaged by looking for ways of continuing and adjusting cooperation before it

is terminated or suspended. CIV has shown that it is better to have a minimum presence (one person) than to manage everything from neighbouring countries or Head Office (no one in the field).

## 5. Guatemala Case Study<sup>8</sup>

### Workstream on service delivery – health subgroup

#### 5.1 Introduction

In 1996 a peace accord was signed between the guerrillas and the government of President Álvaro Arzú, ending the bloody 36-year-long war. Since the peace accord, Guatemala has enjoyed successive democratic elections, most recently in 2003. However, weaknesses in the party system mean that no government has been able to govern for successive terms.

Guatemala is a middle-income country with stable, albeit slow, growth rates. Export has in the past been largely reliant on textiles and agricultures. Almost 40% of the economically active population work in agriculture. Guatemala's society is multi-ethnic, multicultural and multilingual. Of a total population of around 12.7 million, between 40 and 60% are of Mayan origin. Most people live in extreme

poverty, and there is a high correlation between ethnic origin and poverty (ASDI 2005:20).

#### 5.2 The nature of fragility in Guatemala

While the Constitution, the Peace Accords and the social investment plan entitled “Vamos Guatemala” are firmly oriented towards poverty reduction, as are all sector plans, there is still a wide gap between planning and implementation.

Generally, Guatemala does not match the typical criteria of a failing or fragile state<sup>9</sup>, and it certainly does not fit neatly into the OECD's Fragile States Typology. Yet its transparency and governance indicators fall far short of what could be expected after 20 years of transition to democracy, about ten years of post-conflict peace building efforts, and its status as middle-income country. 56% (and in rural areas up to 80%) of the population lives below the poverty line.

<sup>8</sup> This case study was compiled by Barbara Unger, freelance consultant Berlin.

<sup>9</sup> Of three recent classification attempts, only one study places Guatemala among the weak states (Kennedy School of Governance) (DIE 2004: 32f). Aguirre attributes the resistance of Latin American countries towards the notions of fragility and failing states to a deep-rooted commitment to ideas of national sovereignty and the notion of external tutelage connected to state failure. According to Konings/Kruijt, in Latin America there is less the direct destruction of institutions than a process of lost legitimacy because of persisting inequalities (Aguirre 2006). In addition, given that Guatemala is not a low-income but rather a middle-income country, it technically is not subject to World Bank analysis and assistance schemes such as CPIA (Country Policy and Institutional Assessment) and LICUS (Low-Income Countries under Stress Initiative).

Guatemala is more a fragile state in the sense that political will, institutional capacity and delivery of social services fail to guarantee security as well as social, economic and cultural human rights to its citizens, as exemplified by the following aspects:

- **State weakness:** the Guatemalan state cannot exercise a legitimate monopoly over the collective means of coercion across all of its territory, as there are a number of rival parallel forces (the drug trade, ex-security forces, ex-civil patrols (PAC-Patrullas de Autodefensa Civil), youth gangs etc.). Parts of the country (one department, as well as slum areas of the capital) are reported to be out of the government's control and under the control of criminals.
- **Rule of law:** internal legal order exists only on paper, as access to justice is one of the most widely acknowledged gaps in Guatemalan efforts to apply the Constitution and the Peace Accords to everyday life. Land rights and labour relations are in particular flouted in order to benefit the economic elites.
- **Provision of social services:** the fragility criterion of service delivery also applies to Guatemala, which suffers from very weak provision of social services, even though progress is underway in all of the areas mentioned. The main problem remains that influential entrepreneurs, who exercise considerably strong power in the current government, have yet to realise the importance of social expenditure in building social capital with the aim of sustaining growth.
- **The party system:** the party system does not provide for the "long route to accountability", and weaknesses in the system have meant that no government has been able to serve repeated terms.

- **Exclusion:** in all of the afore-mentioned areas, indigenous, poor and female Guatemalans fare substantially worse than the average citizen. The exclusion of broad social sectors has to be taken as yet another trait of state fragility.

- **Low levels of confidence in democracy and government:** all of the previously mentioned elements result in a lack of confidence in democracy, with only 34% of Guatemalans stating that they are satisfied with progress made on democracy (Latinobarómetro, cited in GTZ Governance Assessment Guatemala).

### 5.3 Health sector

Guatemala's Constitution established health as a right of the population, an obligation of the state and a public good (Constitution Articles 93-95). The Peace Accords of 1996 furthermore established free access to basic health and envisaged a reform of the health sector and a pro-poor orientation of services in general.

The main actors of public health provision are the Ministry of Health (MSPAS), the Guatemala Social Security Institute (IGSS) and the municipalities. Beside the public sector, the private sector (profit and non-profit) and traditional therapy play a major role in Guatemala.

MSPAS is in charge of the health sector and is responsible for guaranteeing service provision. While IGSS covers only 15% of the population and is concentrated in urban areas, MSPAS – with its Extension of Coverage Programme – is active throughout Guatemala, although it continues to be biased towards the capital and areas accessible in terms of infrastructure.

The Extension of Coverage Programme has been contracting NGOs since the 1990s for the public health sector, yet the programme has been

unable to reach a significant proportion of the population, and provides a rather reduced package. Typical problems cited include the smallness of the budget, the fact that services are largely provided by a large number of volunteers but very few professional staff and shortcomings connected to the supply-driven approach, which does not take into account traditional health practices or include traditional therapists.

The current health situation in Guatemala is precarious for the majority of Guatemalans. Poor and rural Guatemalans, most of them of Mayan descent, remain at the bottom when charting out health indicators. Maternal and infant mortality are in some areas five times as high as in the urban centres. Access to services is moreover difficult owing to high mountains and little infrastructure apart from the economic hot spots.

Health services and spending on health remains centred in the urban areas. By contrast, remote rural areas tend to receive just one visit per month by a physician, with basic care between those visits being provided by volunteers. Traditional health care, self-care and consulting the pharmacy fill in the gaps in the public system.

The reform of the sector undertaken since the mid-1990s has managed to provide remote rural areas with a very basic package of health services. Yet 1.7 million Guatemalans have no access to even this low level of public health services. Nevertheless, spending in the health sector is below rates in the region, and mainly realised out-of-pocket by Guatemalan households. The Ministry as the steward and main service provider, as the health code stipulates, realises around one fifth of health spending, at around 2% of GDP.

The very low coverage has been alleviated by church and NGO efforts to provide community health services. They have been, apart from traditional healers, the pillar of service provision in

many areas. This can be seen as a *de facto* form of early privatisation due to state weakness (INS 2005).

#### **5.4 The role of international development partners**

Guatemala's international development partners agree that dialogue with the government, the funding of line ministries' programmes and capacity building are the right ways to provide improved governance and better service delivery, thus reducing Guatemala's fragility. However, both on the Guatemalan and on the international community's side, the will to act in a coordinated and coherent manner is weak. This results in piecemeal reforms and aid efforts in a sector that is neither prioritised by the government nor international development partners.

At present, the major international governmental actors in the health sector are the Inter-American Development Bank (IDB) and the World Bank with regard to loans; while the most prominent bilateral donors are the US Agency for International Development (USAID), the Swedish International Development Agency (SIDA) and the Pan American Health Organization (PAHO)/WHO. On the multilateral donor side, the most significant actors are the Joint UN Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA) and the UNDP. In 2003, USAID was the largest bilateral donor in the health sector, followed by the EU and Germany.

Total aid in Guatemala in 2004 amounted to over US\$ 444.300 million, the largest part of which was comprised of loans. A further 38% (US\$ 170.000 million) was in the form of donations. Major donors are the US, Germany, the Netherlands, Sweden and Japan. Loans were provided by Banco Centroamericano de Integración Económica (BCIE), the Inter-American Development Bank (IDB) and the World Bank. According to the IDB's donor

mapping for 2004, international governmental and multilateral donor cooperation (grants and loans) amounts available for health and nutrition stood at US\$ 69.385 million from bilateral agencies, and US\$ 513.710 million from UN agencies.

In terms of cooperation there is only bilateral communication with donors on health in general at the moment. However, there is a growing number of round tables seeking to address specific health aspects, such as immunisation and reproductive health, cross-sectoral efforts such as children's health, and nutrition and recovery after Hurricane Stan. The channelling of 89% of the total of foreign assistance through the government (with the remaining 11% through NGOs) can be interpreted as an expression of trust in the government, and will contribute to strengthening its institutions.

Although no exact data on amounts is available, it seems that building the capacity of the Ministry is the most common approach, although NGO activities do also buffer certain hardships of the Guatemalan poor population. Most donors as well as the NGOs advocate that MSPAS needs support in building capacity to undertake the necessary changes itself.

Donor alignment and harmonisation are weak in the Guatemalan health sector. The existence of different service delivery models is matched by rather patchwork cooperation. This is not an argument against different systems – rather, the problem is that the different approaches are not used to achieve learning effects and synergies, either among Guatemalan health actors or within the international community.

The international donors and national agencies would like to see a sector table which, all actors agree, should be established by the Ministry. While SIDA would like to see a Sector-wide Approach (SWAP), an approach supported by others at least in theory, at present no real joint effort by all parties to establish a SWAP or budget

financing can be detected. A National Health Agenda (Agenda Nacional de Salud, ANS) is to be developed, financed by the IDB, which is, according to the Ministry, a plan which stretches to 2015 and as such outlines the health policy for the next two consecutive governments. The aim of this is to avoid the four-year tides that up to now have characterised the nature of the Guatemalan administration.

### **German support to the Guatemalan health sector**

Guatemala is a partner country of bilateral German DC, with priority sectors in crisis prevention and peace promotion. Until 2004, German DC also supported the health sector, as the third largest bilateral partner after USAID and the EC. The “Primary Health Care Programme” implemented by GTZ focused on building the capacity of the public sector in order to improve the quality of and access to health services, while the financial cooperation projects focused on outsourcing health services to NGOs.

These programmes were regarded as having high potential to support a pro-poor strategy, in particular in the areas of quality of service delivery, drug procurement and empowerment and participation of the local population. Due to the government's lack of interest in fostering this pro-poor orientation through ownership and adequate resource allocation, their success was however rather limited. Some players felt that a higher degree of flexibility in programme design and public partners could have enhanced their success.

Today, German DC continues to support the health sector through the German Catholic Church and the NGO “action medeor”. This support includes cooperation with Instancia Nacional de Salud, an advocacy umbrella of church-based and other non-governmental health organisations that focus on providing advocacy and assisting primary health

care services in rural areas. An explicit aspect of the service provision component is improved access for indigenous groups through the integration of biomedical and traditional health care practices. Operating predominantly outside the public health sector, these programmes are regarded as being quite successful.

### 5.5 Lessons learned and recommendations

State fragility has a major impact on both service delivery and the options to improve it. The health sector reform in Guatemala was undertaken during a period of economic stabilisation, and relies on voluntary work and a very basic “one-size-fits-all” package that cannot compare in price and quality to what other agencies have designed for equally remote and poor areas. Despite these failings, however, learning from different models is not taking place.

The main donors channel aid and loans through the Ministry and support its modernisation. However, reforms have not resulted in a thorough pro-poor orientation. Donors and government agree that governance is an issue, but so far the solution seems to have been to provide management or concepts needed by external consultants instead of building capacity in the headquarters and the departments. This results in a strong relationship of dependency, not only financially, but also politically.

Lessons learned also include the importance of analysing and catering for the demand side when designing programmes. Of course, financing has to be sufficient, which is not the case in the current programmes, again due to the lack of priority given to health services by the Guatemalan Government. Corruption is also present, and while the modernisation of the administration has started, it has not yet borne fruit. On the basis of the lessons learned, the following recommendations can be made:

- It is important to harmonise a national plan among Guatemalan actors and donors. This plan should reflect the interdependency of health issues with nutrition, income and other factors. Ideally, the plan should be the result of a broad consultation process, as there is a lack of a learning culture, which means that important lessons and many chances for synergies are missed.
- Traditional (non-western) ways of dealing with health and illness need to be considered in health approaches and sector reforms. In Guatemalan culture, this mainly refers to Mayan traditions. Failure to address this issue will lead to (continued) inadequate services, ignorance of existing resources and duplication. (ASECSA - the Asociación de Servicios Comunitarios de Salud – can provide examples that show that doing so is more a matter of will and capacity, rather than of budget.)
- Donors need to push for dialogue with government on the issue of pro-poor orientation of public services, with the need to increase spending and therefore also to maximise tax revenues. It would be ideal if donors could come to a joint understanding of matters and act coherently.
- External intervention should aim to achieve maximum flexibility, and should devote sufficient time and resources to the identification of change agents in order to reach objectives in difficult environments. However, it is also important to ensure that these change agents follow a vision of human rights and development, and do not pursue their own agenda.
- “One-size-fits all” solutions should always be avoided, especially in a pluri-cultural society.

## 6. Nepal Case Study<sup>10</sup>

### Workstream on service delivery – health subgroup

#### 6.1 Introduction

In 1990 a multiparty system was introduced in Nepal but failed to produce a stable system of government, with coalitions changing often in the following years. Six years later the Maoists went underground and started a guerrilla war against both the monarchy and the mainstream political parties. This led to a civil war in which more than 13,000 people died. In May 2002 King Gyanendra closed down parliament and dismissed the elected prime minister. His reign lasted for four years until a general strike in April 2006 forced him to reinstate the dissolved House of Representatives.

Today, Nepal has a GNP of US\$ 292 per capita, making it one of the poorest countries in the world. The Nepalese economy is highly dependent on agriculture and 75% of all workers are small-scale farmers.

#### 6.2 The nature of fragility in Nepal

Among the donor community, Nepal is widely accepted to be a fragile state. After a short democratic spell in the early 1990s, the situation has consistently changed for the worse. The political actors, mainly the political parties, have lost most of their credit among the population, and most of the characteristics of fragile states now apply to Nepal.

Nepal does not have a government and state administration that is perceived to be legitimate by the majority of the population. In many rural parts of the country, parallel governance structures exist: the decentralised structures of the elected government, which are mostly restricted to the district headquarters, and a parallel structure set up by the Maoists rebels on the periphery. Both structures levy taxes and fees on specific economic activities.

The Nepalese state does not have the capacity to perform its core functions, particularly in terms of providing welfare and security to its citizens. As regards security, the inability of the state becomes blatantly clear if one considers that Nepal's security forces only control about 25% of the territory. The delivery of basic services such as water, health, education and transport has never been easy in a mountainous country like Nepal, and despite overall development efforts and economic growth, service delivery has deteriorated in most areas.

Another feature characteristic of fragile states – the lack of social cohesion – can also be found in Nepal. Nepal's society is highly segregated, with large parts of the population excluded from public affairs. The exclusion is worst for Dalits (untouchables), who comprise about 20% of the population, alongside members of other lower castes as well as ethnic minorities from the high mountain areas. Women enjoy only limited social status, do not participate actively in political decision-making and have less access to education. The low social status of women, and cultural practices that have been forced upon them, also endanger their lives, and Nepal has the highest maternal mortality rate in the world.

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<sup>10</sup> This case study was compiled by Somraj Acharya from the Human Resource Development Centre, Kathmandu, and Dr. Armin K. Nolting, GTZ, Division Governance and Democracy.

### 6.3 The health sector and the impact of state fragility

#### Health policies and strategies

In all Nepal's health-related policies, including the Second Long Term Health Plan 1997-2017 (SLTHP), the 10th Five-Year Plan and the Health Sector Strategy, the government has repeatedly stated that it seeks to prioritise health and the social inclusion of poor and marginalised groups in the country's development efforts. It is thus true that the specific health needs of excluded groups have been acknowledged at the strategy level. On the other hand, the plans and policies pay little attention to positive traditional practices for maternal and child care, indigenous medicines, local people's beliefs and values on faith healing or traditional human resources who could represent an effective means of reaching the socially excluded populations.

The SLTHP was formulated with broad participation, focusing on all health sector issues. The plan recognises the changing trends in society and excluded groups, whose health needs are often not met: women, children, the rural population, the poor and underprivileged groups. Besides the Health Sector Strategy, there is a clear commitment to move the decentralisation process forward.

In terms of the strategies, the specific needs of excluded groups have clearly been noted and incorporated. However, it is not yet clear how these strategies can be made operational.

#### Health service delivery

Nepal's topographical features and low population density in its rural mountainous districts have always hampered the provision of health services to the whole population. Nevertheless, for a poor country, Nepal has a fairly extensive health system with considerable human resources. In

addition, existing gaps are in many cases filled by non-state actors. The following actor analysis is designed to provide a deeper understanding of the main service providers and their abilities.

The public sector is the main provider of health services in Nepal. Almost 70% of the population relies on the services provided by the government, and in many rural areas the government is the only health sector service provider. The Ministry of Health and Population (MoHP) is responsible for policy direction and planning, human resources policies and mobilisation, financing and M&E. The MoHP has three departments under it, the Department of Health Services (DoHS), the Department of Ayurveda (DoA), and the Department of Drug Administration (DDA). At the district level, the District Development Committee, the District Health Officer and the District Hospital Management Committee are responsible for the delivery and management of health services.

Most of the NGOs implement activities on behalf of donors and international NGOs. As they are heavily dependent on the support of the external agencies, they are often criticised for their lack of independence and flexibility. However, others appreciate their outreach to the most difficult areas, especially in the current conflict situation. There have been reports, however, that NGOs are not welcome in Maoist-controlled areas, as the insurgents doubt their mandate and legitimacy.

The private sector has been growing in Nepal in recent years. Nevertheless, it has been criticised for being limited to urban areas and working for profit, thus not serving the poor and disadvantaged.

In remote areas, people mostly depend on the services of traditional healers who provide physical, psychological and spiritual support that is highly valued by many communities. More than 40,000 female community health volunteers (FCHVs) and more than 10,000 traditional birth attendants

(TBAs) effectively form the foundation of the health system. They work as unpaid volunteers and improve the outreach of the public health system to local-level communities.

### **The utilisation of health services**

Geographic, economic and social factors constrain access to health care in Nepal. Urban facilities are often overstuffed, whereas the opposite is true of district hospitals, health posts and other facilities in remote or conflict-affected districts. Additionally, most of the private health providers and many NGOs are concentrated in the better-off regions of the country, and the health services have become increasingly expensive, so that the poor and underprivileged are unable to pay.

People in remote areas mostly depend on the services of traditional healers. However, although many communities value their services, traditional healers have not been fully recognised by the government.

In Nepal, language can also be a barrier to the utilisation of health services. Many Janajati and Terai groups do not understand or speak Nepali as it is not their mother tongue, which creates an additional barrier to accessing health information and services as these are delivered in Nepali. This affects most of the women and some of the men in these groups.

### **The impact of conflict on the health sector**

Before the armed conflict, the Poverty Reduction Strategy laid down in the policy papers had started to show promising results in the health sector. Thereafter, however, the political will to deliver effective health services began to divide, with the political/national level being forced to address other priorities such as power maintenance, and the technical/operational level continuing with its pro-poor commitment.

The conflict has also had an immediate impact on the government's capacity to implement public health policy in most of the country, given that 80% of the territory is now a conflict area controlled by the Maoists. In addition to the shortage of health workers in conflict areas, the capacity to deliver services is further constrained by destroyed health posts and gaps in logistics/supplies.

## **6.4 The role of external development partners (EDPs)**

External development partners (EDPs) are very important in Nepal. They provide up to 60% of the health funding for the support of the public and NGO health sector in policy and strategy formulation, health promotion and health service provision. The major development partners in the health sector are the World Bank, the UK Department for International Development (DFID), USAID, JICA, German DC, the Swiss Agency for Development and Cooperation (SDC), the WHO, UNICEF and UNFPA, while the main international NGOs include the Britain-Nepal Medical Trust, Care Nepal, Plan International, Save the Children Group, the United Mission to Nepal and Action Aid Nepal.

### **German support to the Nepalese health sector**

Since 1994, BMZ has constantly supported Nepal's health sector. The main activity at present is the Health Sector Support Programme (HSSP), which is jointly implemented by GTZ and KfW Entwicklungsbank.

From its outset, the HSSP has had four complementary objectives:

- 1) To provide policy advice for the national health reform and to strengthen the health system at district level.
- 2) To improve the quality of health care services with a focus on reproductive health.

- 3) To strengthen community health care, and to ensure the social mobilisation of health committees and women’s groups.
- 4) To improve the management of health care facilities and maintenance systems.

The quality component specifically focuses on the participation of women and their daughters in the design of health care services, thereby addressing discriminatory gender-related practices and increasing the voice of local women. It proved possible to continue this component even under conflict conditions, as the topic was regarded as non-sensitive by the conflict parties.

In addition, German DC supports the national Tuberculosis Control Programme in procurement, implementation, training and supervision through the German NGO *Kuratorium Tuberkulose in der Welt*. The support has been successful in terms of good client compliance and programme quality, although the degree of national ownership, in particular under the current conflict situation, is rather weak.

Today, German DC, like many other development partners, is operating in the grey area between development cooperation and humanitarian aid. For Germany, the key trade-off of its health support programme was its ability to adjust flexibly to local situations, with a view to continuing support for the maximum period possible and maintaining an entry point for post-conflict cooperation.

This included the following:

- Flexibility in terms of fund allocation: ensuring the continuation of health services in rural areas using humanitarian-style aid.
- Flexibility in terms of programme changes: from health system development to the maintenance of primary health services. This also includes maintaining a high

human resources base, and having health service providers whose employment by a development partner increases their level of acceptance by the Maoists and provides them with relative protection through the “Basic Operating Guidelines”.

- Flexibility in terms of methodology used to ensure the strict observation of the “Do No Harm” principle: the programme was screened and adjusted to include a strategy for conflict sensitivity and prevention and to achieve a high degree of transparency. Development staff have been trained to implement this approach and other conflict-related soft skills (e.g. how to treat bullet wounds), and receive security advice on a regular basis.
- Flexibility in terms of target group changes: from health workers to the population directly.

### Adjustments to the fragile scenario in Nepal

The EDPs, including those in the German-funded HSSP, have long since started adjusting their work to the fragile framework conditions for health service provision in Nepal. Over time they have improved their coordination, especially since signing a “Statement of Intent” to support the Nepalese health sector reforms.

Throughout the donor community it was also felt that all development objectives and activities need to be made more transparent to avoid the distrust that shapes much of Nepalese public life. Since 2005, the British and German DC agencies have also adopted a so-called “Safe and Effective Development in Conflict” (SEDC) approach which guides adjustments in their programmes/projects to the specific conflict situation.

Positions in a certain district or community are increasingly being filled by local people where

possible. Local people tend to have a better understanding of local social processes, are more able to reach their objectives and, due to their support in the community, are physically safer as well. For similar reasons, EDPs have increasingly entered into partnerships with local health workers, volunteers and CBOs.

The alignment of funds to the national structures, on the other hand, stalled at the onset of the conflict. Donors removed their initial moves towards health sector budget support, as this was perceived to fuel the conflict further.

### Approaches to harmonisation

Before the conflict, there used to be an active dialogue between the government and international development partners through various forums, such as the annual Nepal Development Forum and bi-monthly exchange meetings. These meetings, however, are no longer held. With the onset of the conflict, the absence of government leadership forced donors to increase coordination and harmonisation even further. Good self-coordination has helped them enhance their weight and influence and enabled them to continue their support to the country. Specifically, donor coordination increased their negotiation power with the government and the Maoists, and their common stress on neutrality (e.g. through joint Basic Operating Guidelines) has fostered credibility and acceptance, as well as providing security for their programme staff.

## 6.5 Lessons learned and recommendations

Fragility has not hit the health sector and health service delivery as badly as other service sectors in Nepal (e.g. education). Nevertheless, sustainably supporting the health service delivery systems has been made extremely difficult by the fragile framework conditions in Nepal. What is needed for a more effective health service is peace and

democracy – both objectives that lie well beyond the scope of what development cooperation can manage on its own. It is the social exclusion of large parts of the population that is seen to be the root cause of fragility in Nepal.

At the time these case studies were going to press, the Nepalese state's energy had become fully absorbed by this ongoing conflict, and it is unlikely that major social forces will turn their attention to the health sector before the power struggle has been settled. There are, however, things that Nepal's health sector and its international development partners can do even under difficult circumstances. Engagement in the health sector is acceptable in Nepal's conflict situation. Both the government and the Maoists accord high priority to health service delivery and perceive the sector to be relatively "neutral". This has enabled external partners to remain engaged, and has also provided them with an entry point for short-term negotiation of programme terms, as well as for long-term social inclusion and institution building as a contribution to the stabilisation of the country. In addition, their continued local presence represents an investment in mutual trust between the government and external partners. The following recommendations can be made:

- Neutrality and transparency in all development activities can contribute to stability in an atmosphere of widespread mistrust. Accordingly, hidden agendas need to be avoided, particularly in multi-stakeholder processes, as the transparency of all organisations involved should be a *sine qua non*. Neutrality and transparency are important prerequisites for development partners in the Nepalese conflict, and the formulation of Basic Operating Guidelines and open communication channels to both conflict parties proved to be an important tool for enhancing their credibility and trustworthiness.

- The inclusion of local and traditional knowledge or the collaboration with local mediators as “brokers” can contribute to a better understanding of social dynamics and the necessary adjustments that need to be made to aid approaches.
- The flexibility of international support is key: an extraordinary amount of flexibility is required in terms of the modes of delivery, planning, budgeting and reporting cycles, target-setting, the formulation of objectives, alliances etc.
- Initial experiences with rights-based approaches that consider basic health care more as a human right than a service that can or cannot be offered are promising. Accordingly, this approach should be assessed by other actors in order to integrate often excluded groups like women, children, the elderly, members of low castes and ethnic minorities.
- By ensuring the accessibility, availability and acceptability of services, even external actors can make a modest contribution to social cohesion in Nepal. The way to improve health service delivery to these marginalised groups is to train members of these groups in the health sector or to decentralise authority and resources to local levels.

Attempts to change deeply enrooted social and cultural practices are certainly difficult. If the state system can play a role at all, however, then the health sector – which is one of the most important public employers – is indeed a promising starting point. Good governance in the health sector can introduce important changes within that part of government and society, and might catalyse change within society at large, thus contributing to the long-term stabilisation of the country.

## 7. Yemen Case Study<sup>11</sup>

### Workstream on service delivery – water and sanitation sub-group (WATSAN)

#### 7.1 Introduction

In 2003, Yemen was one of the least developed countries in the world, with a GDP per capita of US\$ 889 (PPP – purchasing power parity) and a Human Development Index ranking of 151 out of 177 countries – the worst performance among the Arab states. The country has a population of 19.7 million, of which 42% lives below the national poverty line. Among the major problems are limited access to basic services, malnourishment (close to 50%), high illiteracy rates especially among females (71%), extreme water scarcity and a very high population growth rate that is estimated to be 3% per year.

The prospects for the Yemeni economy remain poor, with the country's level of economic growth (2.4% in 2005) likely to fall far short of the World Bank target of 8% needed to achieve sustainable development. Besides this, Yemen remains highly dependent on oil revenues, which are gradually dwindling.

#### 7.2 The nature of fragility in Yemen

The recently published “Failed States Index” ranks Yemen eighth out of a total of 60 listed countries. This ranking is based on very low scores for indicators such as uneven development, economic decline, public services and factionalised elites. This however does seem something of an exaggeration: Yemen is certainly not one of the ten most failed states in the world, and the state of

affairs in the country, while far from positive, is very far from that of the Democratic Republic of Congo, Afghanistan or Somalia, which are also classified in this category.

Instead, it seems more reasonable to endorse the assessment of the International Crisis Group (ICG), which defines Yemen as “not a failed or failing state but [...] a fragile one”.

Yemen is one of many examples where state fragility does not derive from the decay of state structures but rather from a historical process of “delayed state building”. From the early 18th century until 1990, there was no unified state ruling the land that comprises the current territory of Yemen, and the country was for a long time split between rival states in the north and the south. A full-scale civil war erupted between the two countries in early 1994, just four years after they had united. Although this situation was resolved, discriminatory state policies continue to threaten the stability of Yemen. Large numbers of southerners have been marginalised in public life and feel that they receive an insufficient allocation of the wealth produced by the country's natural resources (which are mainly located in the south). Therefore the fragility of the Yemeni state can be best framed in institutional terms. Here, state fragility is a condition where the given institutional arrangements in a state embody and preserve the potential for conflict and the conditions of crisis. Besides the above, Yemen faces a situation of “institutional multiplicity”, whereby formal institutional arrangements are seriously challenged by informal rival institutional systems at all levels of society.

<sup>11</sup> This case study was compiled by Stefan Lindemann of the Environmental Policy Research Centre of the Freie Universität Berlin.

Nonetheless, the current Yemeni context can be seen as resembling a situation of (enduring) recovery, in which a stable government is in place and basic state functions are slowly being established. Despite authoritarian tendencies and high levels of corruption, national leaders are demonstrating the political will to make progress on developing the infrastructure of a modern state, although the performance and capacity of government remains rather weak in terms of policy development and implementation.

### 7.3 The Yemeni water sector

Yemen is one of the most water-stressed countries in the world and faces a number of serious problems in the water sector which have to be solved quickly if living conditions are not to deteriorate in many parts of the country.

#### Water resources and water use

In 2000, actual renewable water resources ( $\text{km}^3/\text{year}$ ) were estimated at  $4 \text{ km}^3$ , which amounts to a per capita water availability of  $198 \text{ m}^3/\text{person}/\text{year}$ . This figure is far below the “water poverty line” of  $1,000 \text{ m}^3/\text{person}/\text{year}$ . It is estimated that an extra  $100 \text{ million m}^3/\text{year}$  is needed for the urban WSS sector by 2015. Therefore, the reallocation of water resources from agricultural to domestic and rural to urban use seems inevitable. Beyond dramatic levels of water scarcity, the pollution of water resources has become a growing problem. 95% of the annual water withdrawals are used for agricultural purposes, while domestic use and industry account for 4% and 1% respectively of total water use. If the existing situation continues as it is, then qat farming will in the end deplete rural water and consequently wipe out the rural economy.

With respect to domestic water use, the proportion of unaccounted water (losses) of urban water supply utilities is very high, sometimes approach-

ing between 45 and 50% of water production. At the same time, water demand for domestic use is continuously increasing, especially in cities, owing to rapid population growth and urban migration. It is estimated that an extra  $100 \text{ million m}^3/\text{year}$  is needed for the urban WSS sector by 2015. Therefore, the reallocation of water resources from agricultural to domestic and rural to urban use seems inevitable.

#### Water institutions and policy development

While Yemen had for a long time no water legislation, in 2002 the country enacted a Water Law. It also supports decentralisation in the form of encouraging the formation of basin committees, and requires close cooperation with local councils in the implementation of water management measures.

However, for all of this to translate into effective water management, more than just the legal framework is needed. At present, the institutional and organisational capacities at all levels of government are inadequate for regulating water resources development.

In recent years Yemen has been slowly moving towards a more integrated sector governance structure. This began in 1996 with the bundling of water resources management functions under one entity – the National Water Resources Authority (NWRA) – and was consolidated by the establishment of the Ministry of Water and Environment (MWE) in 2003. For the first time, all agencies dealing with water and environment – with the notable exception of the Ministry of Agriculture and Irrigation (MAI) – are now within the fold of the new ministry (i.e. the NWRA, NWSA, the local councils, the General Authority for Rural Water Supply Projects (GARWSP) and the Environment Protection Agency (EPA)).

While the MWE is generally responsible for sector investment planning and coordination between

all water sector agencies, it is currently still at the capacity development stage and suffers from a lack of competent staff. As a consequence, it has the mandate (through NWRA) but not the power to enforce a more sustainable approach to national water resources management.

Yemen follows an approach of “basin co-management”, whereby stakeholders and state institutions forge a partnership for managing water resources at catchment level. Concerted efforts need to be made to translate this from a management model into reality: while a few basin committees have been formed (e.g. in the Sanaa and Sadah basins), efforts to create community-based water organisations on a wider scale are constrained by the fact that the NWRA at present lacks sufficient financial and human resources and only has a limited regional and local presence. For the co-management approach to work, NWRA has started to prepare regional water management plans for some areas (e.g. for the Taiz, Hadramawt, Tuban-Abyan and Sadah basins); however, the pace of planning preparations remains slow because technical capacities for integrated water resources management (IWRM) are still weak, and the necessary water infrastructure to collect information (e.g. hydro-meteorological monitoring networks, reliable water quality labs etc.) is either non-existent or has only very limited coverage.

Altogether, Yemen has recently made important progress in the institutional and organisational consolidation of its water sector. At the policy level, the National Water Sector Strategy and Investment Plan (NWSSIP) identifies the key sectoral problems and is clearly operationalised. However, the sectoral budget allocations for the next few years remain clearly insufficient in terms of being able to implement the whole array of water policies.

#### **7.4 The water sector and state fragility**

Yemen is still in the difficult process of state building and continues to be affected by institutional fragility – a situation that gives rise to weak state institutions and organisations and creates difficult framework conditions for all sectoral policies, including water.

Furthermore, the case of Yemen illustrates that the relationship between state fragility and the water sector may actually be reciprocal rather than one-way. On the one hand, state fragility has a negative impact on the water sector, while on the other, water-related issues exercise a negative influence on the stability of the Yemeni state. A study conducted by the ICG shows that nearly half the cases of inter-tribal violent conflict are, or were initially, related to land or water. If levels of water scarcity continue to worsen, there is reason to expect increasing internal migration towards the less water-scarce coastal areas – a scenario that implies a high conflict potential and threatens to destabilise the Yemeni state still further.

#### **7.5 The role of international development partners**

The Yemeni government generally adopts a very cooperative approach vis-à-vis international donor organisations. It has actively encouraged far-reaching donor participation in the preparation of the NWSSIP and explicitly welcomes initiatives for better donor coordination.

#### **German support to the Yemeni water sector**

German support started as early as in 1980 and amounted to a total of €232 million for the period between 1980 and 2006. This makes Germany the most important international donor in the Yemeni water sector alongside the World Bank. Yemeni-German development cooperation in the field of WSS is intended to contribute signifi-

cantly to the overarching goal of poverty reduction as formulated in the German government’s “Programme of Action 2015”. Specific sectoral goals include:

- securing the sustainable availability of scarce water resources and providing crisis prevention through IWRM;
- prioritising the demand management side;
- protecting water resources from pollution and over-exploitation;
- securing access for all citizens to clean drinking water and sanitation in order to improve the health situation;
- working towards a decentralised and commercially oriented management of water utilities;
- promoting private sector involvement in the field of service provision and investment;
- facilitating active participation and responsibility on the part of all users (women, farmers, small and micro entrepreneurs, industry); and
- fostering water saving in agriculture through the reuse of water and the application of water-saving irrigation techniques.

The Yemeni government recognises the importance of German support to its water sector, in particular the German multi-level approach. One of the main innovations of German support to the Yemeni water sector is that sectoral reform measures are directly communicated to the affected water users. GTZ-trained community mobilising workers (CMVs), who are mainly women, not only provide training in hygiene and waterborne diseases but also promote the decen-

tralisation and commercialisation of service utilities, using a wide range of culturally sensitive methods.

Overall, German DC addresses the Yemeni recovery setting through a multilevel strategy that combines “top down” and “bottom up” approaches to state building: German development agencies provide comprehensive support to sectoral reform at the macro and meso levels, and to the creation of decentralised and commercialised service utilities at the micro level.

### **Donor coordination**

Coordination between international donor organisations is of crucial importance. Many international donors are currently active in the Yemeni water sector; the largest in terms of aid volume are the World Bank, Germany and the Netherlands. The water-related support provided by the UNDP, Japan, France, USAID and the EU is less relevant. Arab funding organisations (the Arab Fund, the OPEC Fund, the Islamic Bank, the Abu Dhabi Fund) provide erratic but large-scale support that is not at all coordinated. In general, donor coordination has had a mixed record: it may generally have improved in recent years, but there is still little project-related collaboration at the operational level. Where coordination does exist, it takes place purely between the “large” donor organisations.

## **7.6 Lessons learned and recommendations**

Contemporary Yemen is still in a difficult process of state building and continues to be affected by institutional fragility – a situation that may well be especially pronounced in Yemen, but is generally quite common for many low-income countries. The Yemeni case most closely resembles a fragility scenario of (enduring) recovery where a relatively stable government is in place and basic state functions are slowly being established.

Bearing in mind the OECD “Principles for Good International Engagement in Fragile States”, the following recommendations can be made as a result of the German engagement in Yemen:

- Take the context as a starting point and differentiate between sectors. The Yemeni case study underlines the need to calibrate analysis and action to particular country/sector circumstances.
- Focus on state building. The long-term vision for international engagement in fragile environments must focus on supporting the creation of viable sovereign states.
- Intervene at different levels. Donor strategies in recovery settings should combine “top down” and “bottom up” approaches to state building.
- Enhance dialogue and participation. The German TC with the Yemeni water sector offers an innovative example of how to enhance dialogue with water users: project-trained CMVs not only provide training in hygiene and waterborne diseases but also promote and explain the decentralisation and commercialisation of service utilities.
- Move from reaction to (conflict) prevention. This is particularly relevant in water-scarce countries like Yemen, where water-related conflicts constitute an important source of (future) state fragility.
- Align assistance with local priorities. Where governments demonstrate the political will but lack the capacity, international donors should fully align their assistance with government strategies. The German support to the Yemeni water service delivery was fully aligned, as the various projects are all based on Yemeni (sector) strategies and are rooted in Yemeni structures.
- Coordinate between international donors. In the case of Yemen, strategic donor coordination has made important progress in recent years, and the elaboration of the NWSSIP has provided a common reference point in this regard, followed by the “Joint Donor Declaration” in January 2005.

## Annex



### **FRAGILE STATES GROUP (FSG)**

#### **ROOM DOCUMENT 5**

#### **PRINCIPLES FOR GOOD INTERNATIONAL ENGAGEMENT IN FRAGILE STATES AND SITUATIONS (REVISED)**

*At the Senior Level Forum on Development Effectiveness in Fragile States, held in London, 13-14 January 2005, it was agreed that a short list of principles for good international engagement in fragile states be drafted and circulated by the Co-Chairs of the FSG. At the HLM on 3 March 2005, Ministers and Heads of Agencies agreed that the draft principles should be field tested over a period of years.*

*Following the pilot period which will end in December 2006, a revised and final set of Principles will be presented to Ministers and Heads of Agencies of the OECD DAC at the HLM in April 2007.*

*As part of the process towards the HLM, a revised version of the Principles incorporating lessons from the pilot exercise thus far and input from other DAC subsidiary bodies is presented to the 7th meeting of the FSG held on 17-18 October for REVIEW and COMMENT.*

**7<sup>TH</sup> MEETING OF THE FRAGILE STATES GROUP  
WORLD BANK HEADQUARTERS, PARIS  
17-18 OCTOBER, 2006**

## PRINCIPLES FOR GOOD INTERNATIONAL ENGAGEMENT IN FRAGILE STATES AND SITUATIONS

### PREAMBLE

A durable exit from poverty and insecurity for the world's most fragile states will need to be driven by their own leadership and people. International actors can affect outcomes in fragile states in both positive and negative ways. International engagement will not by itself put an end to state fragility, but the adoption of the following shared principles can help maximise the positive impact of engagement and minimise unintentional harm. The Principles are intended to help foster a constructive engagement between national and international stakeholders in countries with problems of weak governance and conflict, and during episodes of temporary fragility in the stronger performing countries. They are designed to support existing dialogue and coordination processes, not to generate new ones.

The long-term vision for international engagement in fragile states is to help national reformers to build legitimate, effective and resilient state institutions. Realisation of this objective requires taking account of and acting according to the following principles:

#### *The Basics*

1. **Take context as the starting point.** It is essential for international actors to understand the specific context in each country, and develop a shared view of the strategic response that is required. It is particularly important to recognise the different constraints of *capacity* and *political will*, and the differences between: (i) countries *recovering* from conflict, political crisis or poor governance; (ii) countries facing *deteriorating* governance environments, and; (iii) countries where progress on development and governance is *static*. Sound political analysis is needed to adapt international responses to country context, beyond quantitative indicators of conflict, governance or institutional strength. International actors should mix and sequence their aid instruments according to context, and avoid blue-print approaches.

2. **Do no harm.** International interventions can also inadvertently create societal divisions and worsen corruption and abuse, if they are not based on strong conflict analysis and designed with appropriate safeguards. Equally, international responses to serious cases of corruption or human rights violations must not exacerbate poverty and insecurity through the sudden withdrawal of aid. In such cases, harmonised and graduated responses should be agreed, taking into account overall governance trends and the potential to adjust aid modalities rather than levels of aid. Aid budget cuts in-year should only be considered as a last resort for the most serious situations. Donor countries also have specific responsibilities at home in addressing corruption, in areas such as asset recovery, anti money laundering measures and banking transparency.

#### *The role of peace-building and state-building*

3. **Prioritise prevention.** Action today can reduce the risk of future conflict and other types of crises, and contribute to long-term global development and security. International actors must be prepared to take rapid action where the risk of conflict and instability is highest. A greater emphasis on prevention will also include sharing risk analyses; looking beyond quick-fix solutions to address the root causes of state fragility; strengthening the capacity of governments and regional organisations to prevent and resolve conflicts; undertaking joint missions to consider measures to help avert crises; and supporting civil society organisations involved in conflict prevention, including women's peace-building initiatives.

4. **Recognise the links between political, security and development objectives.** The challenges faced by fragile states are multi-dimensional. The political, security, economic and social spheres are inter-dependent. Importantly, there may be tensions and trade-offs between objectives, particularly in the short term, which must be addressed when reaching consensus on strategy and priorities. For example, international objectives in some fragile states may need to focus on peace-building in the short term, to lay the foundations for progress against the MDGs in the longer-term. Within donor governments, a “whole of government” approach is needed involving those responsible for security, political and economic affairs, as well as those responsible for development aid and humanitarian assistance. This should aim for policy coherence and joined up strategies where possible, while preserving the independence of humanitarian assistance. Partner governments also need to ensure coherence between ministries in the priorities they convey to the international community.

5. **Focus on state-building as the central objective.** States are fragile when state structures lack capacity – or in some cases, political will – to provide the basic functions needed for development and to safeguard the security and human rights of their populations. The long-term vision for international engagement in these situations is to support viable sovereign states, and should focus on two main areas. Firstly, strengthening the *capability* of states to fulfil their core functions, such as ensuring security and justice; provision of basic services, and establishing an enabling environment for strong economic performance. Delivery of basic services by the state will help encourage citizen engagement with the state-building process. Secondly, supporting the *legitimacy and accountability* of states, by addressing issues of good governance, human rights, democracy and peace-building. Civil society has a key role in both these areas. Demand for good governance from civil society is a vital component of a healthy state, and reinforces its legitimacy and accountability. Civil society may also play a critical transitional role in providing basic services, particularly when the government lacks will and/or capacity.

6. **Promote non-discrimination as a basis for inclusive and stable societies.** Real or perceived discrimination is associated with fragility and conflict, and leads to service delivery failures. International interventions in fragile states should consistently promote gender equity, social inclusion and basic human rights. These are important elements that underpin the relationship between state and citizen, and form part of long-term strategies to prevent fragility. Measures to promote the voice and participation of women, youth, minorities and other excluded groups should be included in state-building and service delivery strategies from the outset.

### *The practicalities*

7. **Align with local priorities in different ways in different contexts.** Where governments demonstrate political will to foster development, but lack capacity, international actors should seek to align assistance behind government strategies. Where capacity is limited, the use of alternative aid instruments – such as international compacts or multi-donor trust funds – can facilitate shared priorities and responsibility for execution between national and international institutions. Where alignment behind government-led strategies is not possible due to particularly weak governance or violent conflict, international actors should consult with a range of national stakeholders in the partner country, and seek opportunities for partial alignment at the sectoral or regional level. Where possible, international actors should seek to avoid activities which undermine national institution-building, such as bypassing national budget processes or developing parallel systems without thought to transition mechanisms.<sup>1</sup>

<sup>1</sup> The Addis Ababa principle developed in November 2001 as part of the Strategic Partnership for Africa Initiative states: “All donor assistance should be delivered through government systems unless there are compelling reasons to the contrary; where this is not possible, any alternative mechanisms or safeguards must be time-limited and develop and build, rather than undermine or bypass, governmental systems.”

8. **Agree on practical coordination mechanisms between international actors.** This can happen even in the absence of strong government leadership. It is important to work together on upstream analysis; joint assessments; shared strategies and coordination of political engagement. Practical initiatives can take the form of joint donor offices, multi-donor trust funds and common reporting and financial requirements. Wherever possible, international actors should work jointly with national reformers in government and civil society to develop a shared analysis of challenges and priorities. In the case of countries in transition from conflict or international disengagement, the use of simple integrated planning tools, such as the transitional results matrix, can help set and monitor realistic priorities.

9. **Act fast ... but stay engaged long enough to give success a chance.** Assistance to fragile states must be flexible enough to take advantage of windows of opportunity and respond to changing conditions on the ground. At the same time, given low capacity and the extent of the challenges facing fragile states, international engagement may need to be of longer-duration than in other low-income countries. Capacity development in core institutions will normally require an engagement of at least ten years. Since volatility of engagement (not only aid volumes, but also diplomatic engagement and field presence) is potentially destabilising for fragile states, international actors must improve aid predictability in these countries, and ensure mutual consultation and coordination prior to any significant changes to aid programming.

10. **Avoid pockets of exclusion.** International actors need to address the problem of “**aid orphans**” – states where there are no significant political barriers to engagement, but few international actors are engaged and aid volumes are low. This also applies to neglected geographical regions within a country, as well as neglected sectors and target groups within societies. As international actors make difficult choices about the partner countries and focus areas for their aid programs, they should seek to avoid unintentional exclusionary effects. In this respect, coordination of field presence and aid flows, and mechanisms to respond to positive developments in these countries, are essential.

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**Bonn Office**

Adenauerallee 139 - 141  
53113 Bonn  
Germany  
Phone: +49 (0) 18 88 535 - 0  
Fax: +49 (0) 18 88 535 - 35 00

**Berlin Office**

Stresemannstraße 94  
10963 Berlin  
Phone: +49 (0) 18 88 535 - 0  
Fax: +49 (0) 18 88 535 - 25 01

poststelle@bmz.bund.de  
www.bmz.de

<b>Responsible</b>	Dr. Eduard Westreicher
<b>Editor-in-chief</b>	Dr. Ludgera Klemp (BMZ), Dr. Ute Schwartz GTZ/BMZ und Armin Nolting GTZ
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