Health & Fragile States Network

Health System Reconstruction: Can it Contribute to State-building?

October 2008

Conducted by the HLSP Institute

Authors:
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Health Systems Reconstruction and State-building

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Key Messages

- There have been increasing attempts to link development aid with the need for improved stability and security at the national, regional and international levels. Building resilient and responsive states in fragile environments is central to this agenda.

- This paper examines whether rebuilding health systems strengthens the social contract between state and society and contributes to state-building.

- The hypothesis is that building health systems contributes to wider state-building by helping to strengthen state capacity and by signalling the increased willingness of the state to act on behalf of citizens in a responsive and accountable manner. This generates enhanced support for the state in return (legitimacy) and a stronger social compact between state and society. Furthermore, the planning, management and delivery of health services contributes to capacity beyond the health sector.

- It was found that health sector strengthening can contribute to state building in the health sector. It can help build legitimacy and capacity, and put health on the state-building agenda.

- The impact of health sector interventions on wider state-building is unclear. There may be more scope for wider state-building and strengthening the state-society compact through decentralized and 'bottom up' approaches, though this needs to be verified through further study.

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Acronyms

AfDB	African Development Bank
BPHS	Basic Package of Health Services
CAP	Consolidated Appeals Process
CBO	Community Based Organisation
CHAP	Common Humanitarian Action Plan
DFID	Department for International Development
DHMT	District Health Management Team
DRC	Democratic Republic of Congo
EC	European Commission
EU	European Union
FBO	Faith Based Organisation
GDP	Gross Domestic Product
GoSL	Government of Sierra Leone
HLF	High Level Forum
HMC	Health Management Committee
HMIS	Health Management Information System
HR	Human Resources
HRM	Human Resource Management
HSS	Health Systems Strengthening
INGO	International Non Government Organisation
IRCBP	Institutional Reform and Capacity Building Program
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTDF	Medium Term Development Framework
NGO	Non Government Organisation
PATHS	Partnerships for Transforming Health Systems
PAVS	Partnership for Voice and Accountability
PHC	Primary Health Care
PRS	Poverty Reduction Strategy
RCHP	Reproductive and Child Health Programme
SEEDS	State Economic Empowerment Development Strategies
SMoH	State Ministry of Health
SPARC	State Partnership for Accountability, Responsiveness and Capability
TRM	Transitional Results Matrix
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United National Development Program
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

Executive Summary

1. INTRODUCTION AND RATIONALE

In recent years, and particularly since 9/11, there have been increasing attempts to link development aid with the need for improved stability and security at the national, regional and international levels. Building resilient and responsive states in fragile environments is central to this agenda.

There is a growing knowledge base demonstrating the importance of good governance in the health sector for effective health systems and improved service delivery. There is also considerable evidence of the impact of fragility on health outcomes. However, there has been very little systematic research into the causal relationships between health and state-building in fragile states, and there are large gaps in our knowledge. This is surprising given that historical experience suggests that responding to social expectations can be central to long-term state survival, and that demands for improved social services, including health, can be key.

The purpose of this study, which was commissioned by the Health and Fragile States Network, is to explore the interactions between health sector strengthening and state-building (Annex A). The guiding hypothesis of this study is that building health systems contributes to wider state-building by helping to strengthen state capacity and by signalling the increased willingness of the state to act on behalf of citizens in a responsive and accountable manner. This generates enhanced support for the state in return (legitimacy) and a stronger social compact between state and society. Furthermore, the planning, management and delivery of health services throughout a state is inherently interdisciplinary and contributes to capacity development beyond the health sector.

To investigate this hypothesis we combined the existing expertise of the authors in health systems and governance with a brief desk-study involving a literature review, and telephone and face-to-face interviews with sixteen health and governance policy-makers and practitioners. We then explored the interactions between health systems reconstruction and state-building through two case studies, Nigeria and Sierra Leone, using local researchers to undertake the fieldwork (Annex B). Approximately twenty respondents were interviewed in each country, including stakeholders in multilateral and bilateral aid organizations, government ministries, international NGOs and local NGOs, field-workers and researchers. Based on our findings, we were able to identify key areas for further research.

2. KEY TERMS

This paper uses inter-linked definitions of state-building, fragile states and health systems strengthening. By *"**the state**"* we mean a political association with the exclusive right to control over a geographic area, and a set of institutions that claim the authority (legitimate power) to make the rules that govern the people who live within its geographical boundaries. State ministries, departments and agencies are the tangible embodiment of the state. States can take many forms – ranging from the legal-rational-democratic model to the patron-client-rent-seeking model. There can be problems when

international funding based on developing a legal-rational-democratic "modern" state meets the realities of a state based on hierarchical patron-client relations.

The concept of ***legitimacy***– acceptance by citizens of a state's right to rule – is central to the concept of the state. Even non-democratic regimes need a degree of legitimacy to survive. Democratic representation has been emphasised by many engaged in state-building as the primary source of legitimacy. However, there are several alternative sources, such as establishing conditions for economic growth; protection from external threats; and growing disenchantment with democratic representation in many countries where liberal state-building is seen to have failed in delivering economic benefits.

A ***resilient state*** requires:

- organisational and institutional capacity (to make and enforce policies, ensure the implementation of state-sponsored programmes, etc.);
- legitimacy;
- access to resources; and
- political processes to manage expectations (the social compact between state and its citizens).

The ***social compact*** is essentially the result of tension between a state and its citizens, in which political elites seek political dominance and in return attempt to meet public expectations of security and economic well-being. Historical evidence suggests that as these basic needs are met, public expectations change and frequently include greater political freedoms.

Together, capacity, institutions, legitimacy, resources and effective processes to support a social compact combine to produce 'resilience'. We use the term resilience to mean the ability of states to withstand and adapt to stress in ways that maintain a creative relationship between state and society. Some states without a strong state-society compact may be able to recover from stress, at least in the short-term. However, if a state has to rely on violence rather than political processes to maintain stability then its legitimacy is at least questionable, and states with weak legitimacy are unlikely to remain resilient in the longer term. They must either adapt to the changing demands of society for a reshaped social compact, or be overtaken by social, economic and political change. A ***fragile state*** is one that lacks some or all of the characteristics of a resilient state.

State-building is the process of developing a resilient state. Ideally it is a nationally led process, though it currently attracts considerable external support. Political dynamics and leaders in many fragile states frequently operate in ways that hinder state-building, although this may not be immediately obvious to the outsider engaged in state building. 'Western' state processes will not always 'fit' societies with different social and political histories. 'Shadow states' may be more common – involving informal networks and manipulation by local elites to enhance their own power and wealth. In shadow states, state failure can involve purposeful strategies that undermine states and encourage patronage. Fragile state rulers may claim sovereignty over a territory but often have little control over large areas. Service delivery can be restricted to urban areas and fail to reach most of the population. In such circumstances, the concept of legitimacy may have little real meaning.

Some observers argue that state-building has evolved from the ***governance*** agenda, although state-building is seen to be more ambitious and have an emphasis on 'foundational' issues. As such state-building is concerned with establishing foundations for the institutions of governance, ensuring the quality and integrity of state institutions and generating state legitimacy, and contributing to a shared sense of the public realm amongst citizens.

Health systems involve six building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship). In fragile states, the building blocks by definition are weak and incomplete – they were either never fully functional or they have suffered from a period of neglect and decay. ***Health systems strengthening (HSS)*** is, essentially, state-building at the sectoral level. This is different from strengthening health services, which does not have the same connotations of a whole system and the role of the state. Not all activities in the health sector contribute to state-building or health systems strengthening.

3. STATE-BUILDING IN THE HEALTH SECTOR

Development partners engage in a wide range of health sector activities. Do these activities contribute to or undermine state-building in the health sector – i.e. help to develop the health system and strengthen the role of the state in the health sector? This can be understood by examining the impacts of short-term versus longer-term engagement, the extent to which government staff are involved in health activities and decisions, and how stewardship, visibility and resource management are dealt with.

Balancing short-term impact and long-term capacity building

Work in the health sector always needs to strike a balance between meeting short-term health needs and developing capacity for sustainable service provision. Whilst clearly an over-simplification, work in fragile states often concentrates on facility-level service delivery or single-issue programmes, with less work on developing local institutional capacity in areas such as procurement, health information and policy-making. Early evidence suggests that good progress can be made with HSS, at least in 'chronically underperforming' states, where health programmes are designed with stewardship as a central objective; where state ownership is nurtured; and when there is sufficient time for improved systems to evolve and be tested.

Involvement of government staff in health activities

In practice, many health sector activities in fragile states tend to focus on service delivery and commodities, which can be (and often are) funded and organised outside the state, often by contracting-out to NGOs. The evidence suggests that contracting-out to NGOs does not necessarily preclude state-building, but there is a risk that it can. Delivering health services and managing health workers are seen by many as key state functions, and transferring these functions to NGOs can undermine states struggling to maintain legitimacy.

Of course, a lot of support for service provision does *not* involve contracting. Government services are often supported directly through a package including salary top-ups and other incentives, training, short- and long-term technical assistance, commodities, money etc. Overall, the effect of international support for health services

on wider sectoral strengthening and state-building depends on how the support is organised. At one extreme, an externally supported state facility may be an island of atypically good resources and atypical service provision, which does not reach out beyond its own facility walls. Such facilities may be widely admired and may improve local health – but the point here is that they contribute little to sectoral strengthening, beyond a possible demonstration effect of good technical practices.

Most practitioners interviewed for this study felt that development partners have a good appreciation of the need to involve government stakeholders, but felt that there is much less agreement on how and when to do this. There are many pressures for a 'quick fix', despite the rhetoric around sustainability. This leads to the state being by-passed, with long-term consequences in fragile states. As one observer commented, "State-building itself is a fragile process and donor behaviour can undermine it".

Stewardship

The term stewardship refers to governance in the health sector and includes leadership and incentives, strategic policy, oversight, regulation and accountability. Stewardship tends to be weak in fragile states, yet there is little documented evidence that suggests a focus on improving stewardship in fragile states. Nevertheless, we found some good examples in Nigeria and Sierra Leone of donor funded programmes explicitly designed to improve stewardship, e.g. Partnerships for Transforming Health Systems (PATHS) in Nigeria, and the Reproductive and Child Health Programme Plan in Sierra Leone.

Visible services and state legitimacy

Improved visibility of health services can contribute to enhanced credibility and legitimacy in the health sector. However mere "visibility" may be a rather narrow concept in state-building terms. Visible services provided by NGOs whose primary accountability is to donors can potentially undermine credibility and legitimacy. Quality in service provision appears to be as important for state credibility

Who controls the resources?

Funding mechanisms for health in fragile states rarely strengthen state systems. Pressures promote a 'quick-fix' approach. Budget support can contribute to HSS and state-building in fragile states if there is parallel governance strengthening in financial management, accountability etc.

Overall, health sector strengthening can contribute to state building in the health sector. It can help build legitimacy and capacity, and put health on the state-building agenda. Context is the key influencer of potential for state-building, but it is often inadequately understood. However, the extent of state-building within the health sector is not systematically understood and more evidence is needed. For instance, there is little, if any, clear evidence on the relationship between health system strengthening, citizen and state expectations and the social compact.

4. INTERACTIONS BETWEEN THE HEALTH SECTOR AND WIDER STATE-BUILDING

The previous section explored the extent to which health sector activities contribute to state-building at the sectoral level. This section takes the argument a step further, by asking, does strengthening the health system extend beyond the health sector and contribute to wider state building? Key questions are:

- Do development partners see health as a valuable entry point into wider state-building?
- Does strengthening the health sector enhance capacity in other institutions?
- Does working at different levels of the state government increase the scope for positive interactions between the health sector and state-building?

Is health seen as a valuable entry point into wider state-building?
The evidence suggests widely conflicting views, though there is very little hard evidence to support the range of views. Most evidence is anecdotal, inconclusive and often reflects organizational interests.

Most policy makers and practitioners feel strongly that the primary objective of health sector initiatives must be improved health outcomes. Most recognize the state-building potential of health interventions as a by-product that can be achieved only if interventions are well designed. Some observers argue that investment in health systems in post-conflict countries has a long-term beneficial effect, as improving health outcomes reduces poverty and thus helps to remove a major risk factor for further conflict.

There is some evidence of improvements in health being used by politicians to gain political support, usually around visible capital development such as new hospitals. It is more difficult to maintain interest in less visible aspects of health such as demand side issues, routine recurrent costs and maintenance. A focus on visibility can undermine routine recurrent costs and maintenance budgets.

The health sector is seen by some as a good entry point for wider state-building as it contains a highly skilled workforce and a relatively good evidence base. Others argue it is a weaker entry point than other sectors which impact more intensively on citizens, e.g. education and water and sanitation. It has also been suggested that the health sector - state-building link may be more of a pre-occupation of the international community than of governments in fragile states.

Does strengthening the health sector enhance capacity in other institutions?
There is very little evidence to demonstrate this either way. Links between the health sector and wider state-building might include connections to other Ministries and core state functions such as financial management and local government decision-making - however the evidence is contradictory. Some observers draw attention to the weaknesses of ministries of health compared to other ministries, while others suggest that achievements in the health sector can serve as a model for other sectors. Evidence from the field was equally contradictory and inconclusive.

Does working at different levels of the state increase the scope for state-building?
The short answer appears to be yes – although the potential for interactions is clearly context-specific and there is a need for caution before generalizations are made. Anecdotal evidence suggests that the state-society compact may be easier to achieve in sub-national governments because of better links and access between citizens and councillors, and strong national support for decentralisation policies enhances this effect. This was supported to an extent by our findings in both Nigeria and Sierra

Leone. However, the risk of 'state-capture' by local elites is well known. Evidence from the field is mixed though does broadly support the view that decentralized services – including health - provide better scope for citizen involvement and a greater willingness to hold local politicians to account. This in turn can promote a stronger response by the local state and help build confidence in public service provision at the local level.

To summarize, the impact of health sector interventions on wider state-building is unclear, and there is little conclusive evidence. There may be more scope for wider state-building and strengthening the state-society compact through decentralised and 'bottom up' approaches, though this needs to be verified through systematic study. Once again, context is a key influencer of the potential for state-building and needs greater understanding.

5. CONCEPTUAL FRAMEWORK

Based on our findings we have refined our guiding hypothesis into two sub-hypotheses:

(i) Some, though not all, health sector activities in fragile states contribute to health systems strengthening i.e. state building in the health sector by:
- building state capacity in stewardship, support systems, institutions and policy;
- signalling increased willingness of the state to act positively on behalf of citizens;
- helping to strengthen the legitimacy of state institutions and improving citizen trust in the state;
- helping to clarify citizens' expectations of the state, and vice-versa, and making these expectations more realistic and manageable, thereby strengthening the social compact around health; and
- improving resource management.

(ii) Some health system strengthening activities have a wider state-building role beyond the health sector by:
- strengthening the capacity of other institutions and sectors;
- strengthening citizen interactions at different levels of the state;
- encouraging citizen involvement in public life; and
- over the long-term improving health outcomes, which reduces poverty and thus the risk of conflict

6. TENTATIVE RESEARCH AGENDA

Whilst there is some anecdotal evidence that health can mitigate state fragility and contribute to state-building, there is little systematic research or empirical evidence. There are considerable gaps in knowledge and understanding, and evidence tends to be inconclusive and contradictory. There is often poor understanding of the impact of context on the challenges of state capacity, political will and state legitimacy, and a tendency for some donors to see state-building as a linear process, a sequence of steps that if managed well will deliver resilient states. Principal questions for further research include:

- What is the role of health systems strengthening in wider state-building in terms of: a) Enhancing institutional capacity for stewardship, oversight, and policy-enforcement; and b) enabling greater state credibility and legitimacy?
- Does improving voice and accountability in the health system contribute to strengthening the social compact between citizens and the state?
- Does improving the effectiveness and transparency of resource management in health contribute to greater trust in the state?
- How does health system strengthening contribute to capacity development in other state institutions, ministries and sectors?
- Does devolved service delivery contribute to state-building at the local level?
- Can building the capacity of the local state create pressures for more responsive and accountable central government?

Overall, there is a need for greater understanding of complexity of context and variations in experience of health and state-building. A strengthened evidence-base will lead to further understanding of the links between health and state-building, and inform both the health and the state-building agendas.

I. Introduction

Since the birth of the new millennium, and particularly since 9/11, development aid has been increasingly linked to attempts to improve stability, promote peace and improve local, regional and global security. The state-building agenda, particularly in fragile and post-conflict settings, is a central part of this evolution. It is believed by many that aid should be given in ways that enhance state ownership and improve government accountability. It is also argued that state-avoiding strategies do not have the reach and scale needed to achieve the MDGs, and are unlikely to promote legitimate, competent and resilient states. For these reasons, state-building is fast becoming part of the orthodoxy of security and development, particularly in fragile states.

Whilst there is considerable evidence of the impact of fragility on health (e.g. Newbrander 2007; Waldman 2007), and a growing literature on the importance of good governance in general for effective health systems and services (e.g. Brinkerhoff *et al* 2008; Lewis 2006, Putzel 2003), there has been very little systematic research into the causal relationships between health and state-building in fragile states. This is perhaps surprising given that much state-building literature suggests that responding to social expectations is central to long-term state survival, and that demands for improved social services, including health, can be key.

The purpose of this study, which was commissioned by the Health and Fragile States Network, is to explore the interactions between health sector strengthening and state-building (Terms of Reference in Annex A). The central hypothesis is that building health systems strengthens the social compact between state and society and contributes to state-building. There are two steps to this hypothesis. First, the delivery of effective health services signals the will and capacity of the state to act on behalf of citizens in a responsive and accountable manner, generating enhanced support for the state in return. Second, the planning, management and delivery of health services throughout a state is inherently interdisciplinary and contributes to capacity development beyond the health sector.

To investigate this hypothesis, we combined the existing expertise of the authors in health systems and governance with a brief desk-study involving a literature review, telephone and face-to-face interviews. We then explored the interactions between health systems reconstruction and state-building through two case studies: Nigeria and Sierra Leone (Annex B). On the basis of a synthesis of findings, we have refined the initial hypothesis and suggest a tentative agenda for further research.

Key informants for the desk research were identified in discussion with the Health and Fragile States Network. Others were drawn from the authors' own experience and contacts, or identified during discussions with other respondents. Most of the informants contacted for the case studies were identified prior to fieldwork being undertaken and based largely on HLSP's long-term experience in both countries in health systems development.

The structure of the paper is as follows:

Section 2 defines key terms: state-building, fragile states and health systems.

Section 3 summarises some of the main activities in the health sector in fragile states and explores the extent to which these contribute to state-building in the health sector – i.e. to developing a health system.

Section 4 explores the extent to which health systems strengthening contributes to wider state-building beyond the health sector.

Section 5 synthesises our understanding of the issues into a brief conceptual framework for field research – presented as a sequence of hypotheses and questions.

Section 6 presents a prospective future research agenda.

II. Key Terms: State-Building, Fragile States and Health Systems

This paper uses inter-linked definitions of state-building, fragile states and health systems strengthening. This section explains the nature of building a resilient state, how health systems strengthening is actually state-building at the sectoral level, and how fragile states are, in effect, the opposite of resilient states.

2.1 The State

It is not particularly helpful to engage in discussions of state-building without a clear understanding of what we mean by the term 'state'. In a formal sense, a 'state' is a political association with effective sovereignty (i.e. the exclusive right to control and governance) over a geographic area. A state usually includes the set of institutions that claim the authority (legitimate power) to make the rules that govern the people who live within its geographical boundaries. State structures are the tangible embodiment of the state, and include government ministries, departments and agencies which act on the instructions of individuals and groups that have gained power. The concept of 'legitimacy' – essentially acceptance by citizens of a state's right to rule – and how it is derived and maintained is central to the concept of the state.

Although the term 'state' can include all institutions of government - traditional and modern, formal and informal – it is more frequently used by development partners to refer to the modern (legal-rational) state system that began its evolution in 15th century Europe, leading to the modern 'world of nation states'. There is often unwillingness on the part of donors to recognise that Western state processes will not always 'fit' societies with different social and political trajectories. As Whaites (2008) argues,

> "Looking more closely at `state-building' allows international actors to consider underlying realities, putting social, economic and political analysis into a historical context. In so doing it helps us to accept that some states may never look similar to our own (and indeed given the realities of their own contexts, why they probably shouldn't)".

Other observers agree on the need to understand the historical evolution of different states, and imply the need for an analysis grounded in political economy approaches. Roberts (2008) observes that in Cambodia, "hierarchical patron-client networks ... have expanded and subsumed the formal state structure". William Reno (2000) adopts the concept of 'shadow states' - informal networks based on neo-patrimonialism and rent-seeking that operate in parallel to formal state bureaucracies. Shadow states are characterised by manipulation by local elites to enhance their own power and wealth. Reno argues that much of the evidence of state failure - e.g. weak public administration, corruption and poor service provision - might be better understood as the purposeful strategies of shadow state rulers. Indeed, he goes further than this, arguing that many shadow state rulers actively seek to undermine state effectiveness to encourage citizens to seek patronage and protection.

Herbst (2000) also sees limitations in fragile states that claim sovereignty over a territory but have, in practice, little control over large swathes of the country. State service delivery is restricted to metropolitan centres and fails to reach most of the rural population. In such circumstances the concepts of legitimacy and the social compact – as understood in the West - may have little real meaning.

2.2 State-building

Whereas we see ***state-formation*** as a long-term, domestically driven process, in this paper we use the term ***state-building*** to refer to deliberate strategies, often designed by external actors, to create or strengthen state institutions and processes.[1]

Understanding state formation – particularly those factors and processes that produce a social compact between state and society – is critical for all those involved in providing international assistance. We see state formation as a process, not a deliberate strategy of action. It can be violent or peaceful, and is rarely a linear sequence of well-ordered steps. It is driven, ultimately, by domestic affairs, and international actors may have little significant influence in state formation processes (Whaites, 2008).

There is a growing literature on state-building. This section does not present a full review of this literature[2]; rather it provides one functional approach to the concept of state-building and explores briefly its core constituents, including notions of legitimacy and the social compact. Throughout we use the concept of resilience – i.e. the ability of states to withstand and adapt to stress in ways that maintain a constructive relationship between state and society.[3]

[1] Ultimately state building must be a nationally led process. External support which fails to take account of the historical processes of state formation will have limited impact and can even undermine progressive sate formation, see e.g. Roberts 2008.

[2] This study was limited in scope and time, and ultimately seeks to identify a more well-defined research agenda.

[3] Some states without a strong state-society compact may be able to recover from stress, at least in the short-term (e.g. Myanmar). However, we would argue if a state has to rely on violence rather than political processes to maintain stability then its legitimacy is at least questionable, and states with weak legitimacy are unlikely to remain resilient in the longer term. They must either adapt to the changing demands of society for a reshaped social compact, or be overtaken by social, economic and political change.

A ***resilient state*** requires:

- Organisational and institutional capacity (to make and enforce policies, ensure the implementation of state-sponsored programmes, etc.);
- legitimacy;
- political processes to manage expectations (the compact between state and its citizens); and
- Access to resources.

State-building refers to strategies of action – often external - to support the evolution of these 'building blocks' of a state.

Fritz and Menocal (2008) believe that state-building can be significantly enhanced by well-targeted, responsive international assistance to build capacity, institutions and legitimacy. They draw particular attention to the "state-society compact" and its institutionalization through "political process or accountability mechanisms through which the state and society reconcile their expectations of one another".

Whilst, for the purposes of this study we have largely adopted this conceptualisation, we recognise its theoretical shortcomings. First, it implies a relatively value-neutral understanding of state-building, suggesting the promotion of legal and rational state forms, such as exist in stable democracies. However, as argued above, political dynamics in many fragile states operate in ways that may be antithetical to modern state forms, e.g. involving elitism, patronage, and clientelism, with leaders who are very able to adapt or reject elements of the external state building agenda to suit their particular needs at any given time (Whaites 2008).

Even where basic security and administrative structures and processes exist, corruption, rent-seeking and neo-patrimonial processes may be common, with limited demand for transparency from an increasingly distrusting population. Much of this may not be immediately obvious to the outsider engaged in state-building activities but will, nevertheless, severely constrain state-building efforts. It is essential to appreciate these realities if externally supported state-building is to have a lasting impact – otherwise international involvement will have a limited, and potentially detrimental, effect on state-building (Jones *et al* 2006).

Second, the model employs notions of consensus-building between state and citizens to achieve a social compact. Historically, social compacts have more often emerged through conflict and struggle – frequently violent - between state elites and society, with elites imposing a political settlement, and state-society relationships being characterised by tension rather than consensus. This can involve the 'violent suppression of ethnic or religious identity, forcible compliance with 'national' laws and norms set by distant and unrepresentative elites, and enforced taxation with a minimum of services delivered in return' (Jones *et al* 2006). Furthermore, there are often sharply different experiences and expectations of the state. Some social groups will not expect the state to deliver either security or services, and indeed will not trust the state to do so. This highlights the difficulties facing some attempts to harmonise social expectations with state functions and capacity – i.e. the process of strengthening the social compact.

Legitimacy is a core constituent of a resilient state. A state enjoys political legitimacy when the people over whom it exercises its authority accept its 'right to rule'. In order to manage the conflicts within a society peacefully, a state needs (at least) passive acceptance of its right to rule by the majority of people. Even non-democratic regimes need to achieve a degree of legitimacy to survive over time. Many achieve this by ensuring the basic delivery of services to their populations.

Yet legitimacy is a complex concept with many different dimensions and is very difficult to measure. There are several alternative sources of legitimacy, based upon, e.g. democratic representation, ideology, establishing conditions for economic growth, and ensuring protection against external threat. Since the 1990s, democratic representation has been emphasised by many as the primary source of legitimacy, although this can be difficult to achieve in states where state institutions are weak. Fragile states are, by definition, particularly susceptible to legitimacy challenges. Furthermore, there is a growing disenchantment with democratic representation in many countries where liberal state-building is seen to have failed in delivering economic benefits, e.g. Russia. The effect has been a further undermining of democratic institutions that are quite weak to begin with, and the considerable erosion of state legitimacy.

The term ***peace-building*** is frequently used – often loosely - in the state-building literature. There is considerable lack of consistency and clarity in the usage of - and differentiation between - the two terms. For us, the term peace-building includes relatively short term actions, often by international actors, to reach a termination of hostilities and to consolidate peace, and is linked to the post-9/11 counter-terrorism agenda. It focuses primarily on actions to institutionalise peace, and as such can be seen to be distinct from state-building.

Of course, peace-builders often aspire to do more than merely end violence, hoping also to create the conditions for a stable peace. This can involve attempting to bring into being the institutions, tools and culture to enable people to settle conflict through non-violent means, including more democratic forms and processes, the rule of law, a market economy free from corruption, conflict management tools and a culture of tolerance and respect. Nevertheless, we believe that essential differences do remain. The urgency to ensure a peace may not necessarily facilitate state-building and peace-building can occur in places where a functioning state already exists (e.g. El Salvador). Peace building can also undermine attempts to create a central state by empowering regional elites. Despite these differences it would seem sensible to align peace-building actions with longer term planning for support to state-building, to provide the foundations for state-building and help bridge short and longer-term issues.

At its simplest, state-building refers to the set of actions to establish, reform or strengthen state institutions. Key goals of international action to build states include provision of security and the rule of law, delivery of basic goods and services and strengthening political legitimacy (Brinkerhoff and Bossert 2008). This is similar to many definitions of ***governance****,* and it can be seen that state-building and governance are closely related. They are concerned with similar issues, in particular how to make institutions work better. Fritz and Menocal (2007) go further, arguing that state-building has evolved from the governance agenda, although it has an emphasis on more fundamental 'foundational' issues, is more holistic and more ambitious.

The authors perceive a central concern in state-building with: (a) establishing foundations for the institutions of governance, without which states cannot operate; (b) ensuring the quality and integrity of state institutions and generating state legitimacy; and (c) contributing to a shared sense of the public realm amongst citizens.

Governance is also concerned with relationships between citizens and the state. Whilst the capacity of state and non-state organisations is important, donors increasingly stress the informal and formal institutions that shape individual and collective behaviour. These institutions are embedded in the way power is held, used and projected in different contexts. They affect relations between citizens, elites, and different political groups in national politics. Improving governance therefore requires institutional change, which can involve changing power relationships through political processes. This conception of governance provides the framework through which many in the international community approach state-building. For (DFID, 2007a),

> "Improving governance is at the heart of building an effective, developmental state because it strengthens consensus among different groups in society about how the country's affairs are managed. This helps to consolidate security and the rule of law. It enables the state to become more stable, with broad legitimacy and capability across all regions and parts of society".

There is little doubt that health systems, the quality of service delivery and health outcomes are strongly influenced by the governance framework within which they operate. These frameworks involve state institutions and policies, non-state actors and civil society, and the relationships between them. They operate at different political, administrative and spatial levels and are rarely static. The 'governance agenda' is, therefore, wide and complex – even in a single sector. Indeed, the health sector embodies some singular characteristics which imply the need for a clearer focus from a governance perspective. These characteristics include: the predominance of public health systems in countries where public sector capacity is weak; the involvement of the private sector and the need for regulation; the difficulties faced by service users and others in judging the quality of care, and the life and death consequences of corrupt practices.

2.3 Fragile states

As stated above, state-building is the process of developing a resilient state which has:

- Political processes to manage the compact between state and its citizens;
- Legitimacy;
- Organisational and institutional capacity; and
- Access to resources.

A ***fragile state*** is one which lacks some or all of the characteristics of a resilient state.

Many states in the developing world, in particular those emerging from conflict or otherwise identified as fragile, fail to meet many of the basic requirements of a resilient state. They may have tenuous control of their population beyond the centre, and their infrastructural capacity (presence of state bureaucracy and services) is often minimal. They have low administrative capacity, low commitment to social welfare and service provision, and can have significant negative impacts on neighbouring states, the region

and the world. They can remain fragile for a long time, and often have risks of regression leading to conflict.

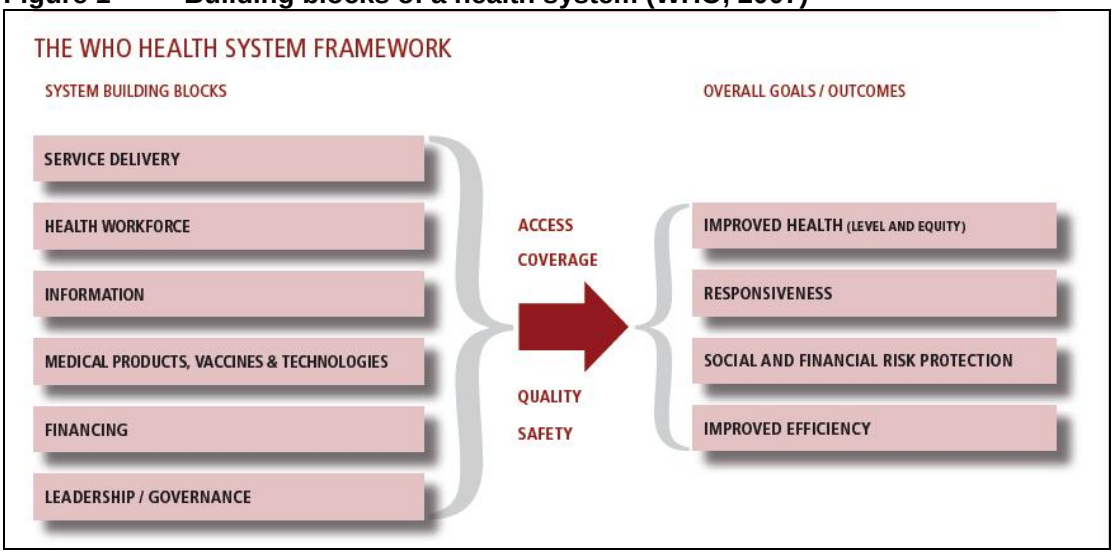
It is widely acknowledged that "fragile states" is a broad term which covers a variety of different situations requiring very different forms of response. The simple categorisation of states into 'weak' or 'strong' is not always helpful. For example, some states may be capable, but oppressive, rather than accountable and responsive, such as North Korea. It is more useful to think of a continuum of fragility and also to consider in which direction a particular country is going – is the situation improving or worsening? Countries which spend years stuck at the weak/fragile end of the spectrum are sometimes called chronic under-performers. A well-studied subset of fragile states is "conflict" and "post-conflict states or more comprehensively, conflict-affected. These may exist at various points along this continuum.

Fragile states grow more slowly that other low income countries - this is clearly an obstacle to reducing poverty. The World Bank (2007) finds that the rate of extreme poverty in current fragile states is growing, which is an important risk factor (and consequence) for conflict. To the extent that there is a relationship between increased wealth and improved health, strengthening health systems and services in fragile states could well make a positive contribution to improving health and decreasing poverty, removing an important cause of fragility and endemic conflict.

2.4 Health systems

This paper uses the WHO description of what constitutes a health system (WHO, 2007). Figure 1 illustrates the six building blocks used by WHO to describe a health system - service delivery; health workforce; information; medical products, vaccines and technologies (commodities); financing; and leadership and governance (stewardship). WHO acknowledges that splitting health systems into these discrete blocks does not reflect the inter-dependence of the blocks – but argues that the building blocks are helpful for understanding and analysing health systems. In fragile states, the building blocks by definition are weak and incomplete – they were either never fully functional or they have suffered from a period of neglect and decay.

Figure 1 Building blocks of a health system (WHO, 2007)



Health systems strengthening is, essentially, state-building at the sectoral level, in so far as HSS objectives include enhanced organisational and institutional capacity to formulate and implement policy; improved relationships between policy-makers, providers and service users (through information, leadership, etc.); more effective governance, stewardship, regulation and legitimacy; and improved resource mobilization and management. This is different from strengthening health services, which does not have the same connotations of a whole system and the role of the state. Note, however, that health systems strengthening does not mean that the state itself has to provide all the services – it can ensure that services are delivered and regulate their quality.

Section 2 Summary

This section defines three key terms and shows how they are linked to each other.

State-building
A state is a political association with effective sovereignty over a geographic area. States can take many forms – ranging from the legal-rational-democratic model to the patron-client-rent-seeking model.

State-building involves purposeful action to support the evolution of building blocks of a resilient state. A resilient state requires:

- organisational capacity;
- legitimacy;
- political processes to manage expectations (the compact between state and its citizens); and
- Access to resources.

Putting in place these building blocks is a blend of sound public administration and developing "acceptable" ways of wielding power. There can be problems when international funding based on developing a legal-rational-democratic "modern" state meets the realities of a state based on hierarchical patron-client relations.

Fragile states
A fragile state is one which lacks some or all of the characteristics of a resilient state. It is useful to think of a continuum of fragility and to consider in which direction a particular country is going – is the situation improving or worsening?

Health systems strengthening
Health systems strengthening (HSS) is a sub-set of activities within the health sector - activities which build institutional capacity to manage resources, provide or regulate services, and ensure there is an acceptable interface between the health system and the population. HSS is essentially state-building at the sectoral level. Not all activities in the health sector contribute to state-building or indeed HSS.

III. State Building in the Health Sector

What are the connections between health system activities in fragile states and state-building? This section summarizes some of the activities undertaken in the health sectors of fragile states and illustrates the types of issue raised for state-building. We then explore the extent to which typical health sector activities in fragile states contribute to state-building.

3.1 Health system activities – issues for state-building

Table 1 identifies common activities in donor funded health sector programmes, arranged according to the health system building blocks, and draws attention to some of the state-building issues that arise. Much of the activity in fragile states focuses on service delivery. The state can be involved to a greater or lesser extent in many aspects of this service delivery – directly as the providers of services, as overseers of non-state providers, as planners and resource allocators etc. A great variety of combinations of activities and actors is possible. A typical scenario may involve:

- Donors funding NGOs to provide services, with the NGOs maintaining tightly vertical systems for monitoring and reporting on resources and financial management. A "patchwork" of operations driven by competing donor priorities, processes and reporting requirements – this is sometimes organised by allocating certain districts to certain funders and/or NGOs. (Laurence and Poole, 2005)
- Specific organisations contributing to particular programmes – immunisation, HIV and AIDS etc. WHO and UNICEF are often actively involved in immunisation programmes.
- Some technical support to the Ministry of Health.
- Funding to rehabilitate the physical infrastructure of health facilities – the state involved to a greater or lesser extent in identifying priority facilities and contractors.

Table 1: Health sector activities and issues for state-building

Health systems building blocks	Typical activities in fragile states (and areas of relative inactivity)	State-building issues raised
Service delivery – provision of services (personal and non-personal health interventions)	• Service provision – health posts, hospitals etc. • Build/renovate facilities • Vertical programmes for priority areas – immunisation, TB, HIV and AIDS etc. • Often distinct, fragmented initiatives and approaches	• Population likes to see health services being delivered; possibility of some "quick wins" • To whom are the service providers accountable? • Is there overall "stewardship" of service delivery in terms of planning, quality assurance etc? • Is there adherence to national norms/standards – about coverage, services to be made available, type of infrastructure to be built? • To what extent are services provided outside government – in non-government facilities staffed by non-government staff?

Health systems building blocks	Typical activities in fragile states (and areas of relative inactivity)	State-building issues raised
Health workforce - sufficient staff, fairly distributed, who are competent, responsive and productive	• Other funders with better salaries may attract health workers away from government jobs • A lot of ad hoc training • May be some systematic pre-service training	• Is there an overall national or regional HR/training plan? • Do low government salaries hamper all progress in the sector? Are any funders willing to systematically support this recurrent cost? • To what extent is training/capacity-building linked to systemic skills? • Is there any consistency in capacity building amongst different funders/providers?
Information - use of reliable information	• Little systematic work – tends to be reliance on one-off surveys etc. • Support in some post-conflict and chronic under-performing states for government health management information system and/or government surveillance systems	• Use of information is a key part of good stewardship and informed resource allocation – who is making these decisions? • Is basic information about non-government facilities and their work shared with government? Are ad hoc survey results shared with government by donors?
Medical products, vaccines and technologies ("commodities")	• Important building block in fragile states – drugs, contraceptives, vaccines, nutrition supplements, malaria nets • Procurement and distribution often done outside government channels • Procurement often fragmented and poorly co-ordinated	• A way of enhancing legitimacy through "quick wins"? • Who has responsibility for logistics, from procurement to distribution? Do parallel systems avoid government? • Are government staff involved at any stage? – e.g. to ensure adherence to an essential drug list or to gain quantification/ procurement skills? • Medical commodities are a highly politicized and desirable resource
Financing – raising funds, protecting population from financial catastrophe	• Often top-down financing with little local decision-making • Government financial management channels not often used. • Few attempts to harmonise donor funding • Resource allocation often quite separate from and out of sequence with government plans about tax, insurance and/or user fees • Information on overall funding levels often not collated and analysed	• How much information does government have on health spending? • Where are decisions made about resource allocation? • National planning systems undermined.

Health systems building blocks	Typical activities in fragile states (and areas of relative inactivity)	State-building issues raised
Leadership and governance - strategic policy frameworks, planning, effective oversight, regulation, partnerships	• May be great fragmentation – of delivery, information, funding etc. • Relatively few activities aimed at improving harmonisation/alignment. Even fewer led by government.	• Government may not be in the driving seat of the sector and some jobs (e.g. regulation of private sector) may not be done at all. • Does anyone take responsibility for looking at nation-wide service provision, concentrating on priority activities, avoiding duplication etc?

A key question is, do these activities contribute to state-building in the health sector – i.e. helping to develop the health system and strengthen the role of the state in the health sector? This question can be broken down into three stages:

- What are the state-building impacts of short-term versus longer term engagement?
- To what extent are government staff involved in health activities and decisions?
- How does this contribute to sectoral state-building?

3.2 Short-term vs. longer-term engagement in fragile states

Debates around short-term versus longer-term engagement tend to focus on the relative merits of humanitarian and development assistance (Commins, 2005). A central question is when it is appropriate to concentrate primarily on short-term effectiveness (in terms of impact on health) and when it is appropriate to balance this with the longer-term (but hopefully more sustainable) process of (re)building the state. As the WHO observe in their framework document 'Everybody's Business', (WHO 2007), "Managing the tension between saving lives and livelihoods and starting the process of re-building the states is a particular challenge in fragile states". This dilemma can be seen in terms of periods of time or different types of activity in the health sector, and is particularly acute in post-conflict situations.

This tension described by WHO is clearly recognizable in the field. Many practitioners argue that the primary need is to deliver basic services now to avert future disaster. One respondent from a leading bilateral agency stated rather more robustly that,

> "People in fragile states need something done about health now. Service delivery people are usually much more ready to act, to take risks, than governance people who want all the systems in place first".

However, many others felt that this need not be an 'either/or' choice, arguing that development partners – particularly those involved in humanitarian assistance - need to be more conscious of the longer term, and to actively seek opportunities to establish foundations for state-building during the humanitarian response. Humanitarian agencies are among the few actors involved in the delivery of frontline services in fragile states, and can be particularly effective in post-conflict situations (Berry *et al*, 2004). However, humanitarian approaches often attract criticism for the relatively short-term nature of their engagements, and because of a perceived tendency to bypass the state and undermine sustainability, at least until more 'developmental' approaches can be

adopted (Waldman 2005a). NGOs may, as one observer put it, "overstay their welcome in humanitarian/emergency mode – avoiding the state and extending the humanitarian footprint". A number of respondents thought that, with few exceptions, international NGOs are state avoiders and undermine state-building. Leader and Colenso (2005) adopt a more balanced view, concluding that humanitarian agencies can make a positive contribution to improving the development outcomes of poor people, even if they are less effective in building sustainable government systems.

The evidence from the field suggests that in practice the distinction between humanitarian and developmental approaches may be less clear than many assume, and that humanitarian agencies often adopt different approaches, depending on context and objectives. For instance, some NGOs may bypass the state where a rapid response is required in an emergency and where the state cannot/will not respond, work in partnership with local NGOs and civil society groups to provide controversial services such as sexual health, and work with state agencies to build technical capacity where the conditions seem appropriate. According to Laurence and Poole (2005) this latter approach, involving formal state partnerships, has become increasingly widespread in the last decade and is based upon the explicit understanding that humanitarian agencies should, where feasible, work with state agencies from as early as possible in an emergency. The benefits of this approach include increased reach and scope of operations, greater potential to scale up, improved access through using local systems, and improved motivation amongst local staff.

Many NGOs see themselves as engaged at the intersection of humanitarian and development work although the primary focus does vary. Many are involved in a range of humanitarian and development interventions, and there is not always a clear operational boundary between the two. In practice, there is often no clear linear progression from 'difficult environment' to 'developmental state'. Situations vary, reversals occur, and governments are rarely 'monolithic', i.e. different parts of the state can demonstrate varying degrees of commitment and capacity. Due to this, both humanitarian and development agencies tend to adapt their interventions to respond effectively.

Furthermore, the balance between humanitarian and development approaches may not be a simple matter of choice. International actors are often feeling their way forward, trying to balance their own strategic interests and humanitarian agendas with those of the country at hand. In most fragile states competing ideologies and rationales are at work, used by different groups – emergency, humanitarian, service delivery, systems strengthening, etc, - and it is often difficult to agree coherent priorities and approaches. Finally, funding organizations may also have different departments with different priorities and mandates, which can also contribute to fragmented approaches.

3.3 To what extent is government staff involved in health activities and decisions?

Table 1 identified some of the issues raised by health sector activities for state-building. In practice, many health sector activities in fragile states tend to focus on service delivery and commodities, which can be (and often are) funded and organised outside government. Less attention is generally paid to core state functions such as policy-

making, regulation, human resource management and collecting and using health information.

There has been considerable interest in recent years in contracting-out service delivery to NGOs, and much of the evidence suggests positive outcomes in terms of service coverage, speed of provision, pro-poor distribution of services and potential for scale-up (see e.g. Palmer *et al*, 2006; Waldman, 2006; Bhushan *et al* 2005). Using data from ten developing countries, Loevinsohn and Harding (2005) found that contracting for delivery of primary care and nutrition services can be very effective and that improvements can be achieved rapidly. Contractors provided greater quality care and achieved better coverage than the state even in poor and remote areas.

In a review of the Afghanistan experience, where contracting-out to NGOs is on a national scale[4], Palmer *et al* (2006) found that NGOs had built up considerable experience in running facilities and delivering health services, and in many ways behaved more like public providers than NGOs, though with greater flexibility. Some have been supported by large international organizations, potentially providing longer term stability. This approach may even have contributed to enhanced state capacity as there is an on-going transfer of people between NGOs and government in Afghanistan. For example, the MoPH has developed improved capacity to regulate health providers. However, fieldworkers interviewed suggested that providing health through NGOs in Afghanistan has been problematic, with contracts being renewed every two or three years, contributing to the break down in relationships, trust and continuity.

Experience from elsewhere suggests that NGO contracting need not harm state legitimacy to a great extent. The issue for many people in fragile environments is that the service is provided. Where NGOs are effective, there is often a common assumption that government is organizing, regulating and managing the process in some way. There is some anecdotal evidence to suggest that where NGOs fail, citizens blame government rather that the NGOs. There are also examples of where merely being associated with resources can enhance legitimacy and confer benefits on the state (Pavignani and Colombo 2001).

Contracting-out NGOs does not necessarily preclude state-building (a resilient state does not necessarily provide health services itself), but there is a risk that it can. Delivering health services, managing health workers and procurement are seen by many as key state functions, and transferring these functions to NGOs can further undermine states struggling to maintain legitimacy; for example in Afghanistan, contracting-out may have contributed to health system fragmentation, with implications for equity and efficiency. In East Timor, Rohland and Cliffe (2002) noted the importance of involving government staff and encouraging “nascent state capacities” from the start, even at the same time as working primarily on community-driven reconstruction and service delivery by the private sector and NGOs. Writing about Kosovo, Shuey (2003) also stresses the importance of involving government staff to support state-building.

4 In Afghanistan donors fund contracts with NGOs worth over US$140 million. Nominally, these cover around three quarters of the population, although not all people may have access to a facility. Twenty-seven NGOs have contracts (17 international and 10 Afghan) lasting 12 to 36 months. They provide a basic package of care, including maternal and newborn health, child health and immunisation, public nutrition, communicable diseases and supply of essential drugs (Palmer *et al* 2006).

In practice, a lot of support for service provision does *not* involve contracting. Government services are often supported directly through a package of one or more of the following – salary top-ups and other incentives, training, short- and long-term technical assistance, commodities, money etc. Similar to contracting, the effects of this on wider sectoral strengthening and state-building depends on how the support is organised. At one extreme, an externally supported state facility may be an island of atypically good resources and atypical service provision which does not reach out beyond its own facility walls. Such facilities may be widely admired and may improve local health – but the point here is that they contribute little to sectoral strengthening, beyond a possible demonstration effect of good technical practices.

Most practitioners interviewed for this study argued that development partners which support NGOs in fragile states have a good appreciation of the need, in principle, to involve government stakeholders, but felt that there is much less agreement on how and when to do this. Some argued that there is often more progress in fragile states than donors acknowledge, and that new donor staff frequently assume there is little to build on, and miss opportunities to contribute to longer-term state capacity development. Others may not understand the context sufficiently well and miss incremental improvements that are 'below the radar'- i.e. below their own perceptions of what exists and what can be achieved. This can bring pressures for a 'quick fix', despite the rhetoric around sustainability.

Many felt donor timetables and funding cycles are too short, and that this can also militate against working through government. Others, it was argued, are guided by immediate pressures and 'diseases of the month' and set up vertical programmes to address them, bypassing government and contributing to fragmentation of the whole health sector, with long term consequences in fragile states. A number of respondents stressed the importance of developing and maintaining relationships of trust and understanding with governments in fragile states, though felt that high staff turnover in development agencies makes this difficult. As one observer commented, "State-building itself is a fragile process and donor behaviour can undermine it".

3.4 How do health sector activities contribute to sectoral state-building?

How do health sector activities contribute to, or undermine, state-building in the health sector? To approach this question we return to the four constituent elements of a resilient state, and examine how health activities affect each of these elements:

- Organisational and institutional capacity to make and enforce policies, ensure the implementation of state-sponsored programmes (i.e. stewardship)
- Legitimacy
- Political processes to manage expectations (the compact between state and its citizens)
- Access to resources.

Stewardship, oversight, delivery and policy-enforcement

Stewardship refers to good governance in the health sector, including leadership and incentives, strategic policy frameworks, oversight, coalition building, appropriate regulation and incentives, attention to system design, and accountability. Whilst much is

said about health sector capacity-building in fragile states, this is generally about developing technical and service delivery skills.[5] Very little is done about developing skills related to state-building in the health sector, even though there is broad agreement about the importance of building capacity for stewardship and improved governance. Not surprisingly, systematic stewardship, policy-making and oversight tend to be weak in fragile states. This is what WHO (2007) has described as the "paradoxical situation in which leadership is weaker than usual because it has been disrupted or divided, but the need for leadership is even greater." Nevertheless, we did find some evidence of a focus on stewardship, including some interesting attempts in our case countries.

Waldman (2006) refers to one of the few health sector capacity building interventions in fragile states that does explicitly prioritise stewardship. This is an EU-funded initiative in the Democratic Republic of Congo that adopts a long-term developmental perspective and has been effective in helping the Ministry of Health to assert and fulfil its stewardship role of the health sector. A key success factor in this programme was its careful design, which does not impose additional management structures that could weaken government ownership.

In Nigeria, DFID is funding the Partnerships for Transforming Health Systems (PATHS), a core aim of which is to improve governance in the health sector, with a focus among other things on stewardship, policy and oversight. Not only is this programme long-term with strong state ownership, but it is also conceptually and operationally linked with two broader governance reform projects - State Partnership for Accountability, Responsiveness and Capability (SPARC), and Partnership for Voice and Accountability in States (PAVS). As one observer stated, "this is the first time a donor has really put its money where its mouth is regarding improved governance in health". It provides a unique opportunity to study the interactions between donor-funded state-building and health strengthening in a complex and poorly performing political environment.

In Sierra Leone, addressing governance challenges is central to most development partners, and stewardship in the health sector is a key element of this. For example, the Reproductive and Child Health Programme (RCHP) is a large multi-donor programme focusing on MDGs 4, 5 and 6, and represents an attempt by all the main donors to focus their efforts around one national plan. The RCHP is at a very early stage. A National Plan has been launched, proposing several components including implementing improved stewardship, policy and strategy development, institutional and management development, operational research and information management, and community involvement. When operationalised, the RCHP could make a major contribution to improved governance in the health sector.

In Afghanistan, Southern Sudan and the DRC, where the governments in power retain overall responsibility of stewardship, Basic Packages of Health Services (BPHS) have helped to establish clear policies and provide a sense of direction for development partners to follow and align with (Waldman, 2006, 2007a). In these countries, provision of a BPHS may have helped to demonstrate state capacity, contributing to enhanced legitimacy.

[5] The indirect capacity building impact of some interventions may go undocumented, such as the demonstration effect of a well-managed network of health facilities.

Developing links and building coalitions with communities is one aspect of state-building which *is* documented. Such links may be in the context of involvement in facility planning, management, monitoring and oversight, drug revolving funds, facility (re)construction and maintenance, etc. Cornwall *et al* (2000) cite the case of a family welfare programme in Nepal that established community consultation processes in the health sector. These evolved into health service management committees which became registered local NGOs involved in setting user fees and addressing procurement delays. Eventually they took charge of local service delivery in co-operation with the public health system.

Legitimacy

Most review papers stress the central importance of service delivery to legitimacy in fragile states (Jones, 2006; Waldman, 2007; Newbrander, 2007; High Level Forum on Health MDGs 2005a and b; Waters *et al*, 2007). Some writers portray involvement in service delivery as laying a foundation for more systems-oriented work that can provide a 'basis from which to address structural constraints' (HLF, 2004). Service delivery is also written about as an activity which is visible and relevant to the population, and which can help raise the morale and confidence of health workers and the credibility of state agencies. In terms of state-building, the crucial questions are who provides these services, who contracts/oversees them and how services are provided.

The most documented issue in terms of state-building-type activities in the health sector is the claim that the visibility of health services gives the state some credibility, and indeed some legitimacy. For example, Rohland and Cliffe (2002) identify physical reconstruction as a positive post-conflict first step, especially if it involves and is driven by the local community. The HLF (2004) called the existence of some functioning health facilities 'islands of dependability', which can be 'crucial in maintaining trust in the health service', although there is little evidence to support this claim. Our case study of Sierra Leone shows that the government-in-exile planned to reinstate selected health services as quickly as possible after the war because of the importance of being seen to be "back in business".

Similarly, Pavignani and Colombo (2001) identified the provision of primary care services in areas that had been occupied by both sides of the war in Mozambique as something that was taken as an early sign of the 'normalisation of civil life'. Moreover, 'the whole process powerfully contributed to the progressive reintegration of rebel areas into a common administration'. The authors contrast this with Angola, where curative urban care was prioritised and the visibility effect was less geographically widespread. Similarly, in East Timor, the lack of visible health services seems to have been an issue and, according to Rohland and Cliffe (2002), "a lack of visible results might have led to increased dissatisfaction and jeopardised the reconstruction process."

Quality in service provision appears to be as important as visibility for state credibility. For example, in Jigawa State in Nigeria, a new type of District Health Authority (the *Gunduma*) is being tested, and has helped to address some of the weaknesses in health financing, monitoring and regulation, and to strengthen the integration of primary and secondary health care. This has made a significant contribution to the quality of health services and helped to build confidence in the health sector, broader public

service provision and in the credibility of the State Ministry of Health (PATHS Review Reports, 2008). Similarly, in Kaduna State, many respondents argued that improved services have increased the level confidence and trust in the SMoH. Meanwhile, in Enugu State, respondents generally felt that the state had little commitment to good services or to the population. Health services were described as poor quality, inequitable and fragmented, and unrelated to community priorities. Citizens' perceptions of the SMoH, and the state government as a whole, were generally negative.

It is difficult to tease out the reasons why the state governments in Kaduna and Enugu appear to behave so differently, and what the implications might be for state-building. More focused research would be needed to clarify the issues. What is clear is that Kaduna State is more responsive and accountable to citizens, with stronger governance processes, and it seems reasonable to assume that this makes progressive state-building and a stronger social compact more likely. This is also implied by recent PATHS Review documents, which state that:

> "Since 2006, the Kaduna state health budget has increased very significantly - and a high percentage of the budgeted money has actually been released for the execution of planned activities. Both of these factors are unusual in Nigerian states and reflect the fact that the Kaduna State Government had a particular interest in the health sector and its governance. This supportive environment was backed up by action - the state government led the development of a number of health-related initiatives, including removing fees for maternal and child health services; the declaration of 'war' on malaria; and the refurbishment of hospital facilities."

The evidence from Sierra Leone also suggests a link between the provision of good quality health services and community perceptions of the state, although this would need to be empirically tested. Immediately after the war, perceptions of the state appear to have risen as the Government of Sierra Leone, with donor support, made rapid progress in improving key services. More recently, support for government appears to be falling, among other things because some services are stagnating or completely failing (secondary health care has virtually collapsed). The decline in government popularity has been tangible, although since the 2007 elections people seem willing to give the new administration a chance to make improvements.

The management of expectations and the social compact

There is very little evidence, either in the literature or the field, about the management of people's expectations of health care in fragile states and what this says about the relative power of citizens and state in the social compact. Tayler (2005) makes the point that these issues are frequently not understood by the international community. There is some evidence to suggest that where formal systems of managing expectations collapse they may be replaced by multiple *ad hoc* arrangements and/or the rule of violence (see e.g. Reno, 2000; Roberts 2008). This can apply to the health sector too – there may be official rules about where services are located and how people access them, but these may be irrelevant in the face of local politics and the distribution of power.

Control over resources

Table 1 indicated that international funding for health in fragile states often bypasses government channels and may weaken a state's control over resources. There may be a number of reasons for this, including aid mechanisms used, low donor confidence in a state's own systems, and the volumes of aid to be disbursed linked to concerns over absorptive capacity.

General and sector budget support contribute to a state's overall policy and expenditure programmes and make use of national financial management, procurement and accountability systems (with additional safeguards where necessary). Budget support is 'on budget' – i.e. taken fully into account in government planning and budget processes, and blended with domestic resources to be spent according to national priorities using national systems. Compared to other aid instruments, budget support can make a powerful state-building impact. However, almost by definition, donors are unlikely to provide budget support in fragile states – because they lack confidence in the government and its financial management systems. Nigeria does not receive budget support from most donors for this reason.

Government financial management systems are not always bypassed in fragile states however. Sierra Leone was provided with budget support from the UK Department for International Development (DFID), aimed at stabilisation and initiating the rapid scale-up of service delivery. Even in a post-conflict, fragile environment this had positive results, providing a non-inflationary boost to public expenditure; providing for a higher real level of recurrent expenditure including in health; securing improvements in service delivery and sector outcomes; improving the overall policy process; and contributing to positive changes in governance and state-building (Lawson, 2007). Similarly, the Swiss Development Cooperation provided sector budget support in Mozambique during the war with positive results (Tayler, 2005). In Kosovo, as Shuey (2003) relates, there was a clear policy of keeping "recurrent government expenditure …within levels that could eventually be generated within Kosovo", demonstrating that development partners were thinking about sustainability and long-term governance issues there.

In the absence of budget support, a wide range of different modalities have been used to channel funds, including the Common Humanitarian Action Plan (CHAP), Consolidated Appeals Process (CAP); the UN Development Assistance Framework (UNDAF); Transitional Results Matrix (TRM), trust funds and the Global Fund (HLF, 2004). Much of the funding provided through these mechanisms tends to be vertical and 'projectised' and involve very little direct state involvement in management. For example, in Southern Sudan, financing generally bypassed government involvement, with the exception of the "shadow-aligned" Medium Term Development Framework. (Waldman, 2007). As mentioned above, government systems in fragile states are also bypassed in situations where donors are under pressure to disburse large sums of money quickly but have concerns about government's limited absorptive capacity (Tayler, 2005).

Control over human resources can be equally significant. Many different funders and providers can be responsible for service delivery, even in one small geographical area, and human resource management can be fragmented and uncoordinated. Turnover in health worker posts may be high, and lack of human resources can be a huge concern

as many migrate and training institutions falter (WHO, 2007). This fragmentation, turn-over and lack of human resources can undermine state-building.

There is often a simultaneous willingness from donors to fund service delivery and an unwillingness to address the issue of low government salaries (which entails supporting recurrent costs). Shuey *et al* (2003) describe this paradox in Kosovo. Inadequate salaries meant that many health workers had to de facto "privatise" some of their work in an unregulated fashion. They noted that not only did this distort service provision and access in the short run, but was likely to prove difficult to reverse in the longer run. This is a major problem in both Nigeria and Sierra Leone, particularly in primary health care.

Section 3 Summary

This section explores the connections between health system strengthening (HSS), health activities in fragile states and state-building. HSS is presented as state-building at the sectoral level.

Balancing short-term impact and long-term capacity building

- Work in the health sector always needs to strike a balance between meeting short-term health needs and developing capacity for sustainable service provision or should this be the health system?.
- Whilst clearly an over-simplification, work in fragile states often concentrates on facility-level service delivery or single-issue programmes, with less work on developing local institutional capacity in areas such as procurement, health information and policy-making.
- Early evidence suggests that good progress can be made with HSS, at least in 'chronically underperforming' states, where health programmes are designed with stewardship as a central objective; where government ownership is nurtured; and when there is sufficient time for improved systems to evolve and be tested.

Visible services and state legitimacy

- Improved visibility of health services can contribute to enhanced credibility and legitimacy in the health sector for the state. However mere "visibility" may be a rather narrow concept in state-building terms. Visible services provided by NGOs whose primary accountability is to donors can potentially undermine credibility and legitimacy of the state.
- Quality in service provision appears to be as important for state credibility

Who controls the resources?

- Funding mechanisms for health in fragile states rarely strengthen state systems. Pressures promote a 'quick-fix' approach.
- Budget Support can contribute to HSS and state-building in fragile states, if there is parallel governance strengthening in financial management, accountability etc.

What is known about the links between health sector strengthening and state-building?

- Health sector strengthening can contribute to state building in the health sector. It can help build legitimacy and capacity, and put health on the state-building agenda.
- Context is a key influencer on the potential for state-building - but it is often inadequately understood.
- State-building is a fragile process and can be easily undermined.

What is not known?

- We do not systematically understand the extent of state-building within the health sector – the evidence is generally anecdotal, inconclusive and shaped by sectional interests.
- There is little if any clear evidence on the relationship between health strengthening, citizen and government expectations and the social compact.
- There is no easy way to disentangle the impact of the health sector on state-building from other interventions.

IV. Interactions between the Health Sector and Wider State-Building in Fragile States

The previous section explored the extent to which health sector activities contribute to state-building at the sectoral level, focusing upon four key aspects: stewardship, legitimacy, the social compact and control over resources. This section takes the argument a step further, by asking, does strengthening the health system extend beyond the health sector and contribute to wider state building? Early desk-based research suggested three key areas for further exploration:

- Do development partners see health as a valuable entry point into wider state-building?
- Does strengthening the health sector enhance capacity in other institutions?
- Does working at different levels of the state government increase the scope for positive interactions between the health sector and state-building?

4.1 Is health seen by development partners as a valuable entry point into wider state-building?

The evidence gathered to address this question suggests a wide range of views, ranging from 'health presents excellent state-building opportunities' to 'health is possibly the worst possible entry point into state-building for a variety of reasons.' However, there is very little hard evidence to support the range of views presented, and much of the evidence provided was anecdotal, often conflicting and occasionally ideological.

There are very few documented cases of the health sector being used explicitly for state-building and very little evidence to suggest that this is an effective strategy. Waldman (2007) documents how USAID did make a direct link between health and peace-building. While USAID's approach to working in health was previously 'primarily for humanitarian reasons', it shifted after 9/11 to factoring in 'political considerations' to a much greater extent, and directed aid towards 'avoiding a return to conflict' (USAID 2004). In practice, this meant attempting to use health to build more stable states, often working in the most fragile and conflict affected areas where health services were in

state of collapse. There is little evidence, however, that this strategy was particularly effective.

Most evidence suggests that both policy makers and practitioners feel strongly that the primary objective of health sector initiatives must be improved health outcomes. Most recognized the state-building potential of some health interventions, though largely as a by-product. This 'by-product' was seen as by no means automatic; health interventions require careful design if any state-building benefits are to be achieved and maximized. For example, the principles of local ownership, partnership and ensuring sustainability are frequently articulated, although, as stated above, the pressures that donors and implementers experience can undermine their attempts to adhere to these principles.

The HLF on Health MDGs (November 2005) asserts that investment in health systems development in post-conflict countries does contribute to consolidating the peace process and lead to more stable states. It advocates that health work should be planned in terms of what it can do to help underpin peace. Yet there is little evidence to support its assertion. More concretely, RAND conducted a review of health in seven post-conflict countries. It concluded from its empirical work that efforts to improve residents' health can generate goodwill and that health can have a significant positive effects, including helping to win "hearts and minds" (Jones 2006).

Health is seen by many as a particularly good entry point for political visibility and popularity and as a contributor to enhanced state legitimacy (See 3.4 above). For example, immunization days were reported to provide valuable photo opportunities for politicians and to contribute to political visibility and popularity. Several respondents referred to cases where the linkages between improvements in health and political popularity had been made explicit in order to gain wide political support, e.g. in DRC, Uganda, Zambia and Nepal. Politicians were keen to maximize their popularity and used developments in the health sector to help achieve this, though efforts were needed to keep political attention focused on aspects other than visible capital development such as new hospitals. As mentioned earlier, in some situations it proved difficult to maintain interest in less visible aspects of health such as demand side issues, routine recurrent expenditures and maintenance. This is a particular issue in Nigeria where the political economy encourages investment in new capital infrastructure, often at the expense of recurrent and maintenance budgets.

A number of respondents felt, intuitively, that the levels of technical skill found in the health sector made it a good candidate for wider state-building. For example, many felt that in states where the health sector has developed a relatively robust evidence base, this could be used to achieve real and visible impact – potentially important for the popularity of politicians and the legitimacy of the state. No hard evidence could be found to support this, although one of the reasons cited in an independent study for the success of decentralized health services in Sierra Leone, compared to other sectors, was that the health sector was populated with better qualified staff and was better informed (Whiteside, 2007).

Some of the literature that sees scope for health to make a contribution to state-building warns against the dangers of over-emphasising the importance of the state-building aspects of health sector work. For example, Waldman (2004) reminds readers that health is a 'desirable end in and of itself' and does not need to be justified on the basis

of economic development or political stability. Duffield (1997) also warns of the dangers to humanitarian organisations of becoming too involved in 'political complexes'. Some of the respondents we interviewed echoed these views, arguing that a focus on state-building and systems development dilutes attempts to improve health outcomes although, once again, were only able to provide anecdotal evidence.

Others were more forthright, arguing that health is a weaker entry point for state-building than other sectors, for several reasons. Some argued that health is a poor entry point as health sector workers tend to focus primarily on technical effectiveness and cost efficiency, and frequently miss the political dimensions and potential for state-building - although this is likely to be the case in other 'technical' sectors as well. In any case, context probably plays a key role. In some instances health is highly politicized, in others it can function more as a technical service. The planning processes in the Mozambican health ministry kept officials engaged during a 'period of military stalemate contributing to a relatively high morale within the MoH and avoiding loss of the key cadres' (Pavignani and Colombo 2001). In contrast, health reforms in Kosovo were in effect undermined by larger political manoeuvring. (Shuey 2003).

Water and sanitation, and education were seen by many as more effective in strengthening links between state and society. As one observer put it: "All families can benefit daily from good water and sanitation; most families from education; and some families benefit now and again from health. It's just a less regularly used service, so it may be one entry point but not the best". It was also suggested that the health sector/state-building link may be more of a pre-occupation of the international community than of governments in fragile states. As the HLF (2005b) concludes: "health tends to represent a minor concern for governments, while remaining a favourite with donors".

4.2 Does strengthening the health sector enhance capacity in other institutions?

There is very little evidence to demonstrate whether strengthening the health sector enhances the capacity of other institutions. Links between the health sector and wider state-building might include connections to other Ministries and core government functions such as financial management and local government decision-making, however the evidence is contradictory. On the one hand, Collins (2002) notes that:

> "Ministries of Health, or their equivalent, are not renowned for their strategic policy-making and policy implementation capacity. They tend to lack the skills, systems and structures to allow them to take on the strategic change role. Neither do they possess the authority within the government to promote change, being often one of the weaker ministries or departments within the governmental structure."

On the other hand, Rohland and Cliffe (2002) do suggest that achievements in the health sector to some extent served as a model for other sectors in East Timor. Bossert (2003) cites a project to improve health and social capital in Nicaragua, where the development of leadership and management skills in community leaders was effective in improving levels of trust in post-conflict communities. This, in turn, had a major

impact on civic and political participation in elections and in advocacy with local officials.

Evidence from the field was equally inconclusive. In Sierra Leone, local governments and District Health Management Teams are responsible for the delivery of primary health care. Local governments have some responsibility for a range of functions central to health (community development, water supply, roads, etc) and the relative success of decentralised health care has helped to raise the profile of these other sectors. In Enugu State, Nigeria, the development of improved planning and budgeting processes in the State Ministry of Health has not yet been rolled out to other ministries, but there is potential to do this. It has also been suggested that new information management systems in the SMoH could be extended to other sectors in the future. In Kaduna state, there was reference to some *ad hoc*, informal transfers of new management processes from MoH to other sectors, e.g. Womens' Affairs, but this was not verified. In both Nigeria and Sierra Leone, finance officers in the MoH are 'owned' by the Ministry of Finance and, theoretically, improvements in MoH financial management and accounting systems could contribute to improvements in the MoF.

4.3 Does working at different levels of the state increase the scope for state-building?

The short answer to whether work at different levels of the states increases the scope for state-building appears to be yes – although the potential for interactions is clearly context-specific and there is a need for caution before generalizations are made.

There is a large literature of decentralized service delivery (e.g. Levers *et al*, 2007; Robinson 2007; ADB, 2004; Mills, 1994), and much of this describes health sector activities at different levels – from central government, through local governments to community level. Interviewees in our study felt that working at different levels of government provides significant scope for state-building, particularly to strengthen popularity, participation, accountability and legitimacy at lower levels of government, and to strengthen the local state/society compact. Anecdotal evidence suggested that this compact may be easier to achieve in sub-national governments because of better links and access between citizens and councillors. This was supported to an extent by our findings in both Nigeria and Sierra Leone. However, as mentioned before, the risk of 'state-capture' by local elites is well known (see e.g. Powis 2003; Bardhan and Mookherjee, 2000). Migdal (2001) argues that government service provision in fragile states often serves the interests of local powerful elites rather than state-effectiveness. Powerful rural elites can make it difficult for states to build political support and legitimacy if local 'strong men' become the brokers for goods, services and security.

Evidence from the field is mixed. Nigeria is a federation with health provided at federal, state, local government and community levels. Local Governments are responsible for primary health care, however they are universally weak, understaffed, underfunded and poorly managed. They have limited capacity and frequently fail to provide even the most basic primary health care (PHC) services. Not surprisingly, local governments have virtually no credibility with communities. However, reviving PHC is a priority of donor-funded health system strengthening efforts, and local government capacity building is central to this. As mentioned earlier, in one state (Jigawa) a new district health model - the Gunduma - is helping to remove some of the disconnects in health

financing, monitoring and regulation, and rebuilding confidence in public service provision.

In Sierra Leone, following the 2004 Local Government Act, responsibility and resources for PHC, agriculture and education were transferred to locally elected councils. All available evidence suggests that the health sector has made by far the best progress. Local Councils collaborate effectively with District Health Management Teams (DHMTs), focusing their efforts primarily on clinic construction and rehabilitation, vaccination campaigns, public health education, and water and sanitation projects. Local Councils currently control 23% of the non-development health expenditures allocated to central and local government and 62% of resources for PHC (Whiteside 2007). It is planned to devolve secondary healthcare to Local Councils during 2008, although the process has been delayed and is currently the subject of debate. Officials from the Institutional Reform and Capacity Building Programme noted significant positive changes in clinic quality, and see greater local autonomy in decision-making in two key aspects: the role of the DHMT in policy decisions, and clinic staff authority over operational issues, such as determining the rates and uses of drug cost recovery funds. They found that community perceptions of local councils have improved considerably since 2004, and that successes in health provision have been core to this improvement.

Section 4 has explored the extent to which health systems strengthening (HSS) contributes to wider state-building. Whilst there are interactions between HSS and state-building, there is little consistent evidence. Where this does exist it is frequently contradictory. This suggests a need for more focused research to provide empirical evidence and a better understanding of the impacts on state-building.

Section 4 Summary

Health as entry point into wider state-building?

- Some regard health as a good entry point into wider state-building; others disagree. There is very little documented evidence either way.
- Health seems to be more a pre-occupation of the international community than of governments in fragile states.

Does HSS enhance capacity in other institutions?

- There is very little evidence to answer this question – opinions vary.
- The Ministry of Health is often a rather low-status ministry in fragile states. It tends to be relatively weak politically, institutionally and financially, with insufficient authority for wider state-building.

Does working at different levels of the state increase the scope for state-building?

- In general, yes, though contexts clearly vary.
- There may be more scope for wider state-building and strengthening the state-society compact through decentralised and ‘bottom up’ approaches.

V. Conceptual Framework

A resilient state requires:

- Organisational and institutional capacity (to make and enforce policies, ensure the implementation of state-sponsored programmes, etc.);
- Legitimacy;
- Political processes to manage expectations (the compact between state and its citizens); and
- Access to resources.

State-building is the process to meet these requirements, i.e. putting in place the building blocks of a state.

The guiding hypothesis of this study is that rebuilding health systems contributes to wider state-building by helping to strengthen state capacity and by signalling the increased willingness of the state to act on behalf of citizens in a responsive and accountable manner. This generates enhanced support for the state in return (legitimacy) and a stronger social compact between state and society. Furthermore, the planning, management and delivery of health services throughout a state is inherently interdisciplinary and contributes to capacity development beyond the health sector.

On the basis of our findings we have refined this into two sub-hypotheses:

(iii) Some, though not all, health sector activities in fragile states contribute to health systems strengthening i.e. state building in the health sector by:
  - building state capacity in stewardship, support systems, institutions and policy
  - signalling increased willingness of the state to act positively on behalf of citizens
  - helping to strengthen the legitimacy of state institutions and improving citizen trust in the state
  - helping to clarify citizens' expectations of the state, and vice-versa, and making these expectations more realistic and manageable, thereby strengthening the social compact around health
  - improving resource management.

(iv) Some health system strengthening activities have a wider state-building role beyond the health sector:
  - by strengthening the capacity of other institutions and sectors
  - by strengthening citizen-state interactions at different levels of the state
  - by encouraging citizen involvement in public life.

These sub-hypotheses form the framework of the tentative research agenda laid out below.

VI. Tentative Research Agenda

Whilst there is some anecdotal evidence that health can mitigate state fragility and contribute to state-building, there is little systematic research or empirical evidence. There are considerable gaps in knowledge and understanding, and evidence tends to be inconclusive and contradictory. There is also limited understanding of the interactions between health and state-building in different situations e.g. conflict-affected, transition situations (deterioration/improvement), and chronic under-performance, and there is a need for greater understanding of complexity and variations. There is a tendency for some donors to see state-building as a linear process, a sequence of steps that if managed well will deliver resilient states. This is a-historical and shallow. Finally, there is often poor understanding of context and of the impact of context on the challenges of state capacity, political will and state legitimacy.

Principal questions for further research include:

1. What is the role of health systems strengthening on wider state-building in terms of: a) enhancing institutional capacity for stewardship, oversight, and policy-enforcement; and b) enabling greater state credibility and legitimacy?
2. What are the state-building links of the relatively 'overlooked' or un-studied health sector building blocks such as the information system in fragile states?
3. Does improving voice and accountability in the health system contribute to strengthening the social compact between citizens and the state?
4. Does improving the effectiveness and transparency of resource management (both financial and human) in health contribute to greater trust in the state?
5. How does health system strengthening contribute to capacity development in other state institutions, ministries and sectors?
6. Does devolved health service delivery contribute to state-building at the local level?
7. Can building the capacity of the local state create pressures for more responsive and accountable central government?

Together, answers to these questions would help strengthen the evidence-base around the role of basic services such as health and state-building. This evidence would allow for a more nuanced understanding of state-building and state-formation, and inform both the health sector strengthening and the state-building agendas.

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Annex A: Terms of Reference

Health and Fragile States Network: Terms of Reference for a Paper on Health Systems Reconstruction and State-building, Dec 18, 2007

Introduction
State-building is one of the new aims of the donor community as fragile states are seen to be a potential threat to both collective and human security. This new focus is encapsulated in one of the OECD's Principles for Good International Engagement in Fragile States, which suggests that focusing on state-building is a new central objective for the aid community. However, there is very little knowledge about how to 'do' state-building, and there is little consensus around conceptual frameworks of analysis.

State-building has been defined as 'support for the state-society contract and its gradual institutionalization."[6] Key to state-building endeavours is building governance structures, governance being defined as "the articulation of a set of political process or accountability mechanisms through which the state and society reconcile their expectations of one another. A focus on governance structures that address inequities and inequalities, and promote accountability are likely over to time to promote stability.'[7]

Service delivery is seen to be one way of promoting the social contract between society and state, and therefore enhancing governance and ultimately state-building. However, the exact dynamics of this interaction remain relatively unexplored, and again, conceptual frameworks of analysis are under-developed. As the health sector is seen to be both a relatively 'neutral' sector, as well as relatively rich in terms of state-society and state-donor interactions, the health sector provides an interesting platform from which to explore ways to build institutions and governance structures. Of particular interest are post-conflict states, where both health sector reconstruction and state-building are important objectives. Developing a conceptual framework from which to analyse these dynamics, and then applying it in the field is an important first step in assessing how aid to the health sector in fragile states could help achieve state-building objectives.

The Heath and Fragile States Network is commissioning a paper on this topic, the second in a series of discussion papers. This work will inform the ongoing work of the OECD-DAC Fragile States Group State-building Work-stream, as well as the OECD-DAC's 'Health as a Tracer Sector' work being done in preparation for the Accra High Level Forum meeting on Aid Effectiveness in Sept 2008. It will also be widely distributed to donors, WHO-HAC, WHO HSS, other UN agencies and NGOs.

Health and Fragile States Network
The Health and Fragile States Network was constituted in June 2007 during a meeting at DfID on health and fragile states. The Network's purpose is to take forward work initiated by the High Level Forum on the Health MDGs (2003-5) and the OECD-DAC Fragile States Group's work-stream on Service Delivery (2005-2006). These initiatives created the momentum for bringing

[6] OECD-DAC Fragile States Group 2007. This paper can be sent to those who wish to apply.
[7] Ibid.

together a network of policymakers, practitioners and researchers to build consensus on effective policy and practice on health in fragile states.

Objectives of the Network

- Foster dialogue and debate, raise awareness and advocate for best practice on a variety of different issues related to health in fragile states.
- Inform and influence policy issues related to health in fragile states.
- Identify research topics, elicit funding for research and commission research in order to strengthen the evidence base for operational practice and inform the policy debate.
- Improve knowledge management by documenting and widely disseminating lessons learned.
- Provide greater visibility to some of the complex aspects related to health services in fragile states in order to promote more and better aid for the sector.
- Encourage linkages between health and broad governance issues, and promote links to other sectors such as education and livelihoods.

The Network is open to participation by individual practitioners and representatives from the many institutions, agencies and service providers (state and non-state) that are involved in research, finance or delivery of health and/or governance programmes and services in fragile states. Network members are represented through a Steering Committee. A Secretariat, based at LSHTM, manages the Network's activities. The Network aims to ensure that it links to relevant existing forums and initiatives, and a mapping exercise is ongoing to identify links and priorities in these relationships.

Focus of the Health and Governance Paper

This paper will develop a conceptual framework from which to analyse the links between rebuilding the health sector, institution-building, governance and state-building. This framework, or certain elements in it, should then be applied in the field to two case studies. It can be divided into two parts. First, what are the different ways that health sector actors (including non-state actors) build, fail to build, or even undermine capacity of the MoH and the broader health system? What is the role (potential and actual) of health service delivery by NGOs and the UN in building national, district and local institutional capacity? How does technical assistance provided by donors build institutional capacity? (50% of paper).

Second, what are the links between health sector reconstruction (such as a functioning MoH; improved service delivery in the district), institution building, broader governance and state-building? For example, does rebuilding the Ministry of Health enhance the functioning of other Ministries? Does government provision of health services improve the visibility of the State, and does this have an effect on the social compact, and state-building? What happens to the social compact when health services are contracted to non-state providers on behalf of the government? What is known about the links between institution building and improved governance mechanisms in the health sector? How do issues of trust and legitimacy influence this process of health sector rebuilding and governance reform? (50% of paper)

As this paper is an initial scoping exercise, the paper should indicate what is know and not known, and outline a prospective research agenda. It should also make a distinction between state-building and peace-building, as these are different processes with different outcomes.

Methods and Timeline
The work for this consultancy will be completed between January and March, with an approved final report due at the end of March 2008. The terms of reference (ToR) will be sent to a range of prospective consultants with an application deadline of 6pm GMT, Wednesday January 9th. To apply, the consultant(s) should submit a two page plan of work, along with a draft budget to olga.bornemisza@lshtm.ac.uk, copied to egbert.sondorp@lshtm.ac.uk. The study should include a literature review, more than 10 interviews with headquarters NGO, UN and donor staff, development of a conceptual framework, and application of this in at least two case studies countries. As there is relatively little literature in this field according to a recent literature review commissioned by DfID (GSDRC, 2007), this paper will focus on collecting primary data from country case studies. The rationale for choosing certain countries should be explained. Once the consultant is chosen by the Steering Committee, they will be asked to prepare a more detailed plan of action in the first two weeks of the consultancy, in collaboration with the Network Secretariat and Steering Committee. There will be a mid-term meeting in London in February 2008 between the consultant, Secretariat and selected members of the Steering Committee to monitor the progress of the project.

Applications to do both ToRs (this one, plus the ToR for a paper on the transitional funding gap), are welcome either by firms, or groups of individuals. Please briefly explain the comparative advantage gained by bidding for both. Consultants may also apply for a single ToR, but they may be asked to communicate and collaborate with the consultants working on the other ToR.

Budget
The proposed budget should reflect the scope of the outputs expected, and include consultancy fees, per diems, travel, insurance and other expenses. An advance of 50% of the agreed budget will be paid as soon as the contract has been signed, with the remainder being paid after satisfactory completion of the task.

Expected Outputs
A detailed plan of action not later than two weeks from the start of the work.
- A short briefing note (2-3 pages) on progress and results to date, submitted in February 2008 for the monitoring meeting in London.
- A final draft report of no more than 30 pages, plus a 4-5 page executive summary (in the style of an ODI HPG briefing paper), plus a concise set of powerpoint slides highlighting the main findings and conclusions.

These are to be submitted to the Secretariat by Monday, March 17, 2008. The Steering Committee will comment on them and give feedback to the consultant(s) by Monday, March 24th. The final document should be completed by Monday, March 31st. The Secretariat will be responsible for facilitating the production of the final document.

Literature
OECD-DAC Fragile States Group. 2007. *From fragility to resilience: concepts and dilemmas of state building in fragile states*. (DRAFT)

Governance and Social Development Resource Centre (GSDRC). 2007. *Healthdesk research report: service provision and state-building.* A literature review commissioned by DFID's Fragile States Team.

Annex B: Case Studies

Fieldwork was undertaken in Nigeria and Sierra Leone to explore the issues and questions defined in the research framework. Nigeria is a federation in which states have a high degree of autonomy, and this can pose particular difficulties for donors. Whilst bilateral agreements are made with the Federal Government, donors have to negotiate a Memorandum of Understanding (MoU) with each different state government. Our fieldwork looked at the interactions between health and state-building in two quite different states: Enugu in the south and Kaduna in the north. Sierra Leone is a unitary state with a high degree of decentralized service delivery. Our fieldwork included interviews with multilateral and bilateral donors, donor-funded programme staff, INGOs, local NGOs and CBOs, government stakeholders at central and local government levels, and other practitioners.

To operationalise our working hypothesis we constructed a series of questions and issues to explore in the field:

(i) Does the political economy context facilitate or hinder state-building?
(ii) What is the international community doing to facilitate state-building?
(iii) What is the international community doing to rebuild the health sector?
(iv) Is health seen by development partners as a valuable entry point into state-building?
(v) Do donors actively seek to strengthen state capacity through health sector interventions?
(vi) Do donor activities in the health sector undermine state-building?
(vii) Are there adequate resources in the health sector to make an impact on state-building?
(viii) Does providing valued public services to the population signal government effectiveness and commitment?
(ix) Does strengthening the Ministry of Health enhance other ministries?
(x) Does working at different levels of government increase the scope for interactions between the health sector and state-building?
(xi) Does providing services through non state actors affect community perceptions of the state or the social compact between state and society, either positively or negatively?
(xii) Does NGO provision of primary health care help communities organize themselves to demand better services from the state?
(xiii) Are their obvious things the international community could do to improve health sector / state-building interactions?

Findings

Does the political economy context facilitate or hinder state-building?

Nigeria

The political economy of Nigeria has three core characteristics. First, successive governments have institutionalized mismanagement of public revenue, particularly from oil. This has seriously damaged the capacity to manage public expenditure and develop

it further. Second, years of military rule, institutionalised corruption and weak accountability have undermined the relationship between Nigerians and the state. Third, institutionalised rent-seeking has undermined activity in non-oil areas of the economy, exacerbating poverty and conflict. An additional point is that Nigeria is a federation, with particularly high levels of autonomy at state level, limiting the potential for centrally driven demands for better performance and accountability.

This political economy directly affects the health sector, which is characterised by:
- Weak leadership and little tangible political commitment to improving health services
- Low state awareness that health should be a priority
- Low resource allocation for health
- Serious leakage in fiscal transfer system for service delivery
- Little transparency and accountability
- Performance management affected by patronage and corruption
- Low expectations from society and little pressure for change.

Nigeria's political economy severely limits the opportunities for service delivery and state-building to interact positively.

Sierra Leone

Sierra Leone's current social and economic situation has been shaped by the civil war (1991 – 2002). The war paralysed the economy, caused the collapse of public services, destroyed the country's infrastructure, and incapacitated government institutions. Up to two million people, around half of the country's population, were displaced (DFID, 2007b). Years of poor governance, corruption, exclusionary politics and poverty contributed to the conflict. Despite some improvements, many of these features of governance persist and Sierra Leone remains fragile.

In 2008, Sierra Leone constitutes a mixed picture in terms of governance and development. There have been improvements in capability, accountability and responsiveness but starting from an extremely low baseline. Successful national and local elections have taken place, and a number of institutions and laws for effective governance are in place. There has been significant progress in introducing reforms within the security sector, and the police and armed forces are now more effective. However, accountability is weak, and oversight bodies such as the Parliament, Ombudsman and Anti-Corruption Commission do not provide strong oversight over the Executive. There is limited political will for greater accountability. Civil society is not yet able to hold government to account. Political participation is poor but improving. Lack of capacity across Government and civil society is a major constraint. However, the establishment of local government and devolution of resources and functions from central level to local government has had positive results. Sierra Leone is on a positive trajectory, but again is starting from a very low base, and the continuation of patronage politics, marginalisation, exclusion, and corruption, which is draining and diverting limited resources present major challenges for state-building.

What is the international community doing to facilitate state-building?

Nigeria

Nigeria is categorized by many in the donor community as a 'chronic underperformer' and poor governance is seen by many as the fundamental constraint to development

progress. It is not surprising then that improving governance is a central priority for the international community in Nigeria. However, importantly, Nigeria in not aid-dependent, which limits the influence donors have to shape behaviour there.

Most of the major multilateral and bilateral agencies and INGOs are present in Nigeria, many working in partnership with others. Overall priorities include:

- Access to Justice for the poor;
- Enhanced transparency and accountability for better governance: anti-corruption, public expenditure management, public administration and service delivery, accountability and oversight, citizen voice and demands for change;
- Democratic governance and human rights.
- Improved environment and services for non-oil development including support to State Economic Empowerment Development Strategies (SEEDS)
- Encouraging citizen voice in governance and service delivery.

Programme stakeholders in Kaduna agreed that their activities in capacity building of state and local government, institutional development, influencing legislation, advocacy and civil society development constituted state-building, although the term was not mentioned in MoUs with states. In contrast, interestingly respondents in Enugu were reluctant to draw any relationships between their actions and state-building, arguing that they were essentially 'technocrats' involved in technical – not political – development.

Sierra Leone

Since 2002, the international community has worked with the Government of Sierra Leone (GoSL) to make the transition from conflict to development. National elections took place in 2002, and local government was re-introduced after a period of some thirty years in 2004. Donor support was initially aimed largely at improving the capability of the state to maintain peace and start the difficult process of rebuilding state organisations such as the police, judiciary and security sectors. As the country moved towards a more developmental phase, donor support in the justice and security sectors focused on improving accountability and responsiveness to the population, e.g. through community policing. Other state-building support has included improving tax collection, an Extractive Industries Transparency Initiative to improve management of diamond resources, establishment of an Anti-corruption Commission, public financial management systems and support to civil society scrutiny, better oversight and regulation.

Current state-building initiatives are clustered around a major Public Service Reform Strategy. This involves many of the main donors (WB, DFID, EC, AfDB, UNDP). Support is provided for functional reviews of state ministries, state restructuring, civil service capacity building, records management, HRM, pay reform and leadership development. Donors, led by the WB, are also supporting a major Institutional Reform and Capacity Building Project (IRCBP) aimed at improving public sector finances and decentralized governance. DFID supports a programme to promote better information, community voice and transparency in elections.

USAID and UNDP provide support to local government and civil society to improve voice and accountability.

What is the international community doing to rebuild the health sector?

Nigeria

In Nigeria, donors are undertaking a wide range of health interventions, from health sector reform to systems strengthening and narrowly focused service delivery. The majority of personnel involved in these programmes do not perceive an explicit link between their interventions and state-building. However a few do seek to link their health sector interventions to improved governance. For example DFID has funded the Partnerships for Transforming Health Systems (PATHS) since 2002 and has recently extended it into a second phase. PATHS focuses on strengthening stewardship of the health sector, with a focus on policy, strategy development, budgeting, accounting, health financing, HR, HMIS, integrated health systems, an essential package of health care, and engagement with non-state providers. It also helps strengthen community involvement and community demand for health services.

Not only is this programme long-term, but conceptually and operationally linked with SPARC and PAVS. As one observer stated, "this is the first time a donor has really put its money where its mouth is regarding improved governance". It provides a unique opportunity to study the interactions between donor-funded state-building and health strengthening in a complex and poorly performing political environment.

Sierra Leone

In Sierra Leone, slow progress in achieving the MDGs is a major concern and there is a strong sector focus on health, education, and water and sanitation. Tackling governance challenges in these sectors – including corruption and lack of capacity – is seen as central by many development partners. The Reproductive and Child Health Programme (RCHP) is a large, ambitious multi-donor programme focusing on MDGs 4, 5 and 6, and represents an attempt by all the main donors to focus their efforts around one national plan. The RCHP is at the very early stage. A National Plan has been launched and has wide support, though exactly how GoSL will engage and seek to operationalise the plan is yet to be seen. The Plan itself proposes a nation-wide programme with several components including implementing a package of essential services, policy and strategy development, institutional and management development, operational research and information management, and community involvement. The RCHP is intended to work at central and local government levels, in the context of on-going decentralization, and strengthening governance is perceived by many as essential to programme success.

USAID manages a separate project on HIV and AIDS. UNICEF has financed the construction of new maternity wings to the Kenema and Koinadugu hospital and the rehabilitation of several health facilities nationwide.

Several European bilateral agencies also provide humanitarian support. There are also several smaller initiatives, many managed and led by local and international NGOs. Some of these focus on building community capacity to engage in health supply and demand, although most do emergency work and direct service delivery in specific sub-sectors, such as TB and leprosy.

Is health seen by development partners as a valuable entry point into state-building?

Nigeria

Virtually all of the bilateral agencies and INGOs in Nigeria felt that health was part of a wider state-building agenda, and a valuable entry point, mainly because of its inclusion in SEEDS. In Kaduna, the primary objectives of SEEDS are: to build trust and confidence in governance; to reduce poverty (among other things through improved service delivery); and to eliminate negative values in society. Improving government legitimacy is at the centre of Kaduna's SEEDS.

Transformation of the health sector is a key strategy in SEEDS, and many development partners feel it is a good entry point into broader governance, through e.g. more transparent planning and budgeting, better information and access to health and education, and greater social awareness of health services. This was echoed by a national NGO in Enugu, where one respondent argued that improved access to health promoted a sense of belonging and 'patriotism'.

Others in Enugu felt that health makes a significant contribution to state-building in several ways. For example, improving maternal and child health raises family expectations for a better future and promotes the sense of a stake in the future. The phrase 'health is wealth' was repeated a number of times, the argument being that better health can lead to less crime, and fewer social ills such as unwanted pregnancies and abandoned children.

A number of donors felt intuitively that the MDGs could be seen as part of state-building, though were unable to identify explicit relationships. Interestingly though, officials in UN organizations contacted took a distinctly different position. They argued that health is a poor entry point for state-building compared to more direct interventions in civil service reform, elimination of corruption, electoral reform and education. With respect to health, they argued that the Nigerian government demonstrates little commitment, as evidenced by levels of investment, neglect of secondary and tertiary health, failure to maintain existing systems, and so forth. Some argued that more direct intervention in health is required, "bypassing state government institutions" if necessary.

Sierra Leone

In Sierra Leone, health was seen as one of the key sectors for strengthening linkages between state and society. Immediately after the war, the international community provided assistance to the new government to rehabilitate core infrastructure. The priority was to rebuild 'state symbols', including parliament, courts, prisons, health facilities, schools and roads, to persuade communities that the war was indeed over and that the state was back in control.

Support to the Ministry of Health and Sanitation (MoHS) started with the re-opening all district hospitals and community health centres in chiefdom headquarter towns. This was seen as necessary to attract displaced people back to their localities. Interestingly, many displaced people had experienced relatively good health care in refugee camps, and returned with demands for similar service levels of care. Initial support to rehabilitate facilities and improve health services was provided by the WB, the AfDB, the Islamic Bank, the EC and UNICEF, as well as a raft of INGOs. Much of this work

continues today, though the degree to which it is perceived as directly 'state-building' is variable and probably limited.

Do donors actively seek to strengthen state capacity through health sector interventions?

Nigeria

Most donors in Nigeria recognize the need to strengthen governance as part of their sector programmes, though do not use sector programmes primarily for state-building. All donors work through MoUs with state governments, contributing to SEEDS and trying to strengthen state government ownership of donor supported intervention to achieve the MDGs. The impact of these efforts is unknown and appears patchy.

In Nigeria, DFID and the WB have formed a strategic partnership to address governance issues. Improving health sector stewardship is central to this agenda. UNDP supports improved voice and accountability as part of its HIV and AIDS programme in one state. The World Bank in Enugu trains MoH officers on procurement and financial management (though this is primarily for the purpose of implementing World Bank projects). The impacts of health sector programmes on wider state-building are largely unknown.

In Kaduna, donor agencies are building community voice in health, and supporting community structures to engage in health care demand and supply. This was seen to be a direct contribution to state-building. Some respondents felt there were some broader impacts, e.g. when officers move to new posts, bring new knowledge and skills to other sectors. However the precise impact of this is unknown.

Sierra Leone

In Sierra Leone, most donors do not use health as a direct entry point into state-building, though most recognize the importance of state-building per se, and the need for improved governance in the health sector. For example, key weaknesses defined by stakeholder during fieldwork included:

- Governance and stewardship
- Leadership, management and supervision
- Strategic policy and decision-making
- Coordination and communication with the MoHS
- Planning, budgeting, procurement and accounting systems
- Enforcement of laws and regulations.

However, by and large, for most practical purposes state-building and health strengthening are seen as distinct and treated separate and un-linked.

Does donor support for health undermine state-building?

Nigeria

Most development partners in Nigeria are aware that short-term support for service delivery can contribute to undermining state capacity, particularly if it bypasses government. Consequently many have adopted long-term, strategic approaches aimed at building institutional capacity and fostering longer term sustainability. The major

donor-funded health programmes in Nigeria do appear to contribute to state-building, and are designed and implemented with core governance objectives in mind. The interrelationships of PATHS, SPARC and PAVS are probably the best example of this. Some NGOs do focus explicitly on short term service delivery, e.g. providing ITNs, de-worming children, etc. with little focus on sustainability issues and this could, in the long term, undermine state capacity. The key determinant appears to be the extent to which NGOs work with, or ignore, government priorities, institutions and processes.

Sierra Leone

Most donor support in Sierra Leone has focused on PHC. Combined with donor support for decentralized governance and capacity building at district level, the net effect has been positive for state-building at the local level. However, there is little or no integration, and secondary and tertiary health service have all but collapsed. The phrase 'an undeclared emergency' was used a number of times when referring to urban and secondary health provision.

At the central level, there is some evidence that donor actions may, indeed, be undermining state capacity. For example it is common practice for donors to fund some local civil servants with salary top-ups. Whilst this need not necessarily be destructive, the net effect of this on the MoHS as a whole is ambiguous. Whilst a few departments may have the scope to function more effectively, it has created jealousies and reduced the morale and willingness of staff in other departments not attracting donor support. There do not appear to be obvious system-wide benefits deriving from this piecemeal support, and in fact the Ministry in Freetown is virtually moribund.

Furthermore, some donors support the establishment of new departments and units within the ministry primarily to implement 'their' programmes. This can involve the transfer of staff from existing departments into better resourced ones, thereby further undermining overall capacity. The approach can be seen as creating centres of technical excellence or, alternatively, placing cuckoos in the nest. Pressure on donor staff to spend quickly and deliver on the MDGs appears to be driving this approach. Finally, predicting donor funds appears to be difficult. Most donor projects have a life between zero and three years ahead, so there is little knowledge of donor funds more than a year ahead.

Are there adequate resources in the health sector to make an impact on state-building?

Nigeria

In Nigeria, state health budgets are often as little as 2 or 3% of overall budgets and much of this 'leaks' out of the system before reaching the front line. Ultimately, it is not a question of resource shortages, but what happens to the resources that do exist, particularly the massive oil revenues. This is primarily a question of governance and accountability, rather than the quantum of resources per se. Donor funds tend to fill gaps and try to leverage greater commitment and finance from government for health and governance, to date with little success.

Sierra Leone

WHO (2006) estimates that Sierra Leone spent 7.9% of total public expenditure on health in 2003. Since 2003, expenditure on health has declined, both in absolute terms

and as a proportion of GDP. In 2003, health expenditure exceeded 2% of GDP. In 2005 it was 1.1 percent. The current budgeted allocation in Sierra Leone is less than US $3 per capita.

Actual expenditure falls far below the allocated budget. For example, in 2007 actual expenditure on health was 27% of budgeted allocation. Low expenditure in 2007 reflected two factors that were outside the control of the MoHS: a wider fiscal problem of revenue failures and unbudgeted expenditure to finance the 2007 election. The collapse in funding was widely felt throughout the health public service. Hospitals have received no drugs or other supplies since 2006, and Districts had received only one or two of their quarterly transfers of funds. The net effect has been a decline in health services and a weakening in community trust of the state.

While donor funds have made important contributions to meet the shortfall, in some ways they have added to the problem of instability. Contributions to public health financing by foreign donors have been very much larger than GoSL expenditure, so fluctuations in donor funding can far exceed the total value of GoSL expenditure.

Does providing valued public services to the population signal government effectiveness and commitment?

Nigeria

This issue drew a range of responses, evidently based upon quite different experiences. In Kaduna, respondents felt that good service provision does increase the level community trust in government, and stimulate greater social participation in service provision and the political process in general. The state's popular Free MCH Policy, which has widespread support, was cited as an example

Respondents in Enugu generally felt that the state government had little commitment to good services or to the population. Services were described as poor, inequitable and fragmented, and unrelated to community priorities. The impact on perceptions of government was generally negative.

These responses do seem to indicate a link between the quality of state service provision and community perceptions of government, although there may be other 'socio-cultural' differences at work here. For example, respondents in Enugu stated that communities tend to see free services as inferior, precisely because they are free, and will not use them as they imply users have a low socio-economic status. We were unable to verify this, although one respondent felt that the issue of 'socio-cultural' differences was important and should influence the design of donor-funded programmes, which often assume 'one size fits all'.

Sierra Leone

There does seem to be a correlation between the provision of health services and community perceptions of the state, although this would need to be empirically tested. Immediately after the war perceptions of the state appear to have risen as GoSL, with donor support, made rapid progress in rehabilitation key infrastructure and services. More recently support for government appears to be falling, among other things because some services are stagnating or worse, completely failing. The decline is

government popularity was tangible, although since the 2007 elections people seem willing to give the new administration a chance to make improvements.

Does strengthening the Ministry of Health enhance other ministries?

There is little or no direct evidence to answer this question in either Nigeria or Sierra Leone. In Enugu, the development of improved planning and budgeting processes in MoH have not yet been rolled out to other ministries, but there is potential to do this in PATHS 2. It has also been suggested that new information management systems in the MoH could be extended to other sectors in the future. In Kaduna state there was reference to some ad hoc, informal transfers of new management processes from MoH to other sectors, e.g. Womens' Affairs, but this was not verified.

In both Nigeria and Sierra Leone, finance officers in the MoH are 'owned' by the Ministry of Finance and, theoretically, improvements in MoH financial management and accounting systems could contribute to improvements in the MoF.

In Sierra Leone there was some evidence that decentralising health services helped strengthen the integration of sectors at district level, providing greater scope for the transfer of improved systems, e.g. in linking health to water and sanitation and road maintenance, although this needs to be tested empirically.

Does working at different levels of government increase the scope for interactions between the health sector and state-building?

The short answer appears to be yes – although the potential for interactions is clearly context-specific and there is a need for caution before generalizations are made.

Nigeria

Nigeria is a federation with health provided at federal, state, local government and community levels. The Federal Constitution contains no details on specific health service roles and functions, and there is an almost total absence of integration across the different levels. Some states appear to be reasonably effective in health service delivery (e.g. Kaduna) and in these situations community confidence is growing. In others, the State Ministry of Health has little if any credibility and there appear to be limited opportunities for positive interactions between health and state-building.

Local Governments in Nigeria are responsible for PHC. Innovative experiments like the Gunduma in Kaduna state notwithstanding, however, they are universally weak, understaffed, under-funded and poorly managed. They have limited capacity and frequently fail to provide even the most basic PHC services. Not surprisingly, local governments have virtually no credibility with communities. However, reviving PHC is a priority of donor-funded health system strengthening efforts, and local government capacity building is central to this. There is considerable scope here to test the hypothesis that improving health services at the local level contributes to (local) state-building.

Local communities in Nigeria have largely 'abandoned' the state-run PHC system as it has let them down so often and for so long. A few PHC facilities have operational Health Management Committees, and these provide a channel through which citizens

can articulate their concerns. Citizens appear keen to be involved in HMCs, even (especially?) where local government involvement has been poor, to help ensure facilities remain functional. Some states have succeeded in reviving community interest through the use of radio stations for community mobilisation. The evidence, though limited, suggests reasonable potential for health to provide an entry point to improve community voice and engagement in state-building.

Sierra Leone

Following the 2004 Local Government Act responsibility and resources for PHC, agriculture and education were transferred to locally elected councils. All available evidence suggests that the health sector has made by far the best progress. Local Councils collaborate effectively with District Health Management Teams (DHMTs), focusing their efforts primarily on clinic construction and rehabilitation, vaccination campaigns, public health education, and water and sanitation projects. Local Councils currently control 23% of the non-development health expenditures allocated to central and local government and 62% of resources for PHC (Whiteside 2007). Secondary healthcare was devolved to Local Councils in 2008. IRCBP officials cited significant positive changes in clinic quality, and see greater local autonomy in decision-making in two key aspects: the role of the DHMT in policy decisions, and clinic staff authority over operational issues, like determining the rates and uses of drug cost recovery funds. They claim that community perceptions of local councils have improved considerably since 2004, and that successes in health provision have been core to this improvement.

Does providing services through non state actors affect community perceptions of the state or the social compact between state and society, either positively or negatively?

There was no consensus around this issue, and no hard evidence to support the various positions offered.

- In both Nigeria and Sierra Leone, a majority of MoH officials felt that using NGOs had a negative effect on perceptions of government, as it indicated "failure of the state" and "failed government relationships with the society". However others, especially in the NGO sector, commented that it depends on the exact balance of responsibilities between government and NGOs, and how transparently this balance had been negotiated.

- Donors tended to argue that service delivery through government structures was a more effective way of ensuring sustainability, though not necessarily the best way to provide services speedily.

- Community representatives in Nigeria argued that NGOs provide better services, and that "government officials hijack programmes whenever they are involved". This suggests that many communities already have little trust in government and expect little from state providers. They appear to have greater trust in non-state providers. In this situation it will clearly take a huge effort to re-establish confidence in government, and it is clear that issues of trust and legitimacy will be central in shaping health sector rebuilding and governance reform.

Does NGO provision of primary health care help communities organize themselves to demand better services from the state?

There was little evidence to suggest this was occurring in either Nigeria or Sierra Leone. In Nigeria, the tendency appeared to be that, where NGOs are effective in delivering health services, community relationships with government weaken even further. In Enugu, there appeared to be little trust in government and few expectations of service delivery. NGOs play a central role in service delivery at all levels there, and are popular and effective. This has not stimulated greater community pressure on government to improve its service delivery.

There was some suggestion that NGOs working in urban areas in Sierra Leone have helped communities to organize themselves more effectively, but negative perceptions of government remain.