Department for International Development
United Kingdom

Service Delivery and Social Protection in Fragile States

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CREATING A NATURAL ADVANTAGE

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Abbreviations and Acronyms

ADB	Asian Development Bank
CPIA	Country Policy and Institutional Performance Assessments
DFID	Department for International Development
FSG	Fragile States Group
GDP	Gross Domestic Product
IDA	International Development Association
ILOs	International Labour Organisations
ISSA	International Systems Security Association
LICUS	Low-Income Countries Under Stress
MDGs	Millennium Development Goals
NGO	Non-Governmental Organisations
ToRs	Terms of Reference
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation

This report has been prepared by Monica Burns and Clare O'Brien (as consultants for NI-CO) for DFID, through the DFID Economist Resource Centre framework. The views expressed herein are those of the authors and do not necessarily represent the views of DFID, Enterplan Limited, or the wider ERC consortium.

Contents

1 Introduction

1.1 Purpose of the Work

1 This document is a report on the first stage in a programme of work envisaged in the terms of reference for a study on 'Financing Service Delivery in Fragile States' (see Annex 1 for ToRs). The first stage (para 1. on page 4 of ToRs) is an exploratory one to review the questions outlined in pages 1-3 of the tors, the available data, and to the extent it is possible from existing published data produce aggregate data on these questions for the matrix of 46 fragile states.

2 The broad purpose of the work is to define better the case load of people in extreme poverty in fragile states and to understand better what social assistance and basic services they can access, irrespective of the source. Following the DFID publication in January 2005, 'Why we need to work more effectively in fragile states' the impetus to scale up services in fragile states began. The aim now is to try to get a better picture of the order of magnitude of the problem rather than precise (almost certainly unavailable) figures showing unmet need.

3 Social indicators in fragile states are notoriously difficult to capture, are often collected for specific purposes which may inflate or deflate the real figures, and where figures exist they carry caveats and cautions about dependability and accuracy. Many fragile states do not have the basic denominators (such as recent census figures to indicate population) from which to assess the usual parameters of access to basic health care and other social protection provisions. Humanitarian and aid organisations use figures for access to health and social protection services to reflect the need to parent organisations for resources, many of which provide services in kind (usually through NGOs) rather than as direct transfers or in directly managed projects. The distinction between direct transfers and in-kind provision further muddies the already dubious figures, in terms of resource allocation.

4 The questions posed by the work fall into three broad categories:

- What is being spent on service delivery and social protection in fragile states?
- How are the resources being spent?
- On whom are the resources being spent?

5 Looking at these issues from the specific perspective of 'fragile states' is to take a different 'cut' at a subject, which is already receiving significant attention among the international community.[1/] Many international organisations, multilateral and bilateral, are addressing the challenge of getting appropriate services to the most vulnerable and poor, many of whom live in fragile states. There is a risk that

1/ For example, World Bank's 'Low income countries under stress' (LICUS), ADB's Social Protection Index, ILO Modelling on basic social security, and DAC Fragile States Group, sub group on service delivery.

data sets developed for the various permutations for aid and development, which are already loaded with caveats and cautions, create a confused and unclear picture, since they are addressing marginally different groups.

1.2 Approach

6 The current attention in development on the MDGs and data relating to movement towards those targets, means that there is now more consistent information available generally about poor countries than, say, six or seven years ago. The data used for the purposes of this work come from a wide range of organisations and, after discussions with DFID's Fragile States Team about the purpose of this initial assessment of the issues, the data elements were distilled into a small number. The tables presented in the report are purposely limited to a small number of variables which seek to address the specific purpose of the work, which is to better define the case load of people in extreme poverty in fragile states and to better understand what social assistance and basic services they can access, irrespective of the source of funding or provision.

7 In addition to available data sets, a number of documents were issued or were available in draft form during the course of the research for this work. These were reviewed to identify potential linkages to and relevance for the scaling up the work of the Fragile States Team. Three documents in particular have relevance in the context of poverty and state fragility, and their potential use is discussed later in the report. They are: ADB's Social Protection Index for Committed Poverty Reduction 2006 (which was issued on 4th August 2006), ILO's draft paper 'Can low-income countries afford basic social protection? First results of a modelling exercise' (April 2005 draft) and, finally, ILO's draft paper 'Issues in social protection; Costing of basic social protection benefits in selected Asian countries: first results of a modelling exercise' (July 2006 draft). The two latter papers applied the same approach in a range of sub Saharan African countries and subsequently in a range of selected Asian countries, to test the viability of the model and general applicability. ADB's social protection index is potentially applicable across all countries.

8 As a first step in approaching the issue, the field was wide open to suggestions about how to address the issues as they relate specifically to fragility, for the longer term. There was no overwhelming desire to create yet another data collection, collation and analysis mechanism which would inevitably overlap in essential data elements with numerous others in the field of aid and development. Rather, this initial approach was to try to address the first stage questions and to make proposals about how best DFID's Fragile States Team might take the issues forward, bearing in mind the commitment to scale up the investment and the effectiveness of the assistance in fragile states, to help states move towards stability and the improvement of health and wellbeing through achievement of the MDGs.

1.3 Definitions, Descriptions and Sources of Data

1.3.1 Fragile States

9 The concept of fragility is itself laden with caution and caveats, with different international organisations adopting slightly different definitions and therefore encompassing different, though overlapping, countries. DFID does not limit its definition of fragile states to those countries affected by conflict, but does take into

account the core functions of state including territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people sustain themselves.[2/] Despite this working definition, DFID has chosen to adapt the World Bank CPIA list low income and unranked countries as the list of 'fragile states', with the explicit understanding – and caution - that countries can and do move in and out of fragility. Fragile states, as defined by the World Bank, do not include middle-income countries. So, the list adopted by DFID reflects fragile states, which are poor or unranked, but not those, which might fall into 'middle income' or 'transition' categories.

10 DFID's proxy list of 46 fragile states is based on countries' rankings in the World Bank's Country Policy and Institutional Performance assessments (CPIA) between 1999 and 2003. Each year the World Bank compiles a set of CPIA ratings for the 81 countries, which are eligible for assistance from the International Development Association (IDA). The CPIA rates the performance of each country in terms of its economic management, structural policies, social inclusion and public sector management, and gives an overall score ranging from one to six. For DFID, the 'fragile states' are those that fell into the bottom two quintiles of the CPIA ranking table (i.e. roughly the 30 countries with the lowest score) in any year between 1999 and 2003, plus those that were unranked. This leads to the list of 46 countries cited in DFID's policy paper.[3/]

11 Three observations are worth noting in relation to this definition of a fragile state. First, the only countries that may get a CPIA rating are those eligible for IDA assistance, which itself presupposes that the country already meets criteria for good policy performance (as well as criteria for relative poverty and lack of creditworthiness). A country that fails to meet this minimum requirement for assistance would not be able to appear on the list. Second, the World Bank's focus in recent years has been on low-income countries under stress (LICUS), a category defined as those countries with a CPIA rating of less than 3.0. Countries can move in and out of the definition of LICUS from one year to the next. This LICUS category tends to comprise fewer countries than those in the bottom two quintiles: just 15 countries fitted the LICUS criteria in 2005. Thus there are countries on DFID's list of fragile states (e.g. Kenya), which were never in the list of LICUS between 1999 and 2003. Thirdly, because eligibility for IDA grants is a basic criterion for inclusion on the CPIA list, the list therefore excludes middle-income countries and most countries in transition. Other countries, which might be expected to appear on the fragile states list, are not there.

12 The acceptance of the 46 identified countries as fragile states (despite the surprising appearance of some countries on the list and the absence of others) helps to focus attention on some of the basic social protection issues, to determine in the first instance if the data are consistently available and, if so, what that data might indicate in terms of the most vulnerable groups in these fragile states.

2/ DFID, Why we need to work more effectively in fragile states', January 2005
3/ DFID (2005), 'Why we need to work more effectively in fragile states'

1.3.2 Social Protection

13 Different international organisations define social protection in different ways and include different provisions. The lists of provisions range from access to basic health care, through old-age pensions, to education. The International Labour Organisation and the Asian Development Bank have specifically identified social protection provisions and while there are significant overlaps, the lists are not exactly the same. Given the paucity of data and its lack of robustness for the identified fragile states, four basic parameters of data were chosen for this work by which to make an initial assessment of what is being spent on social protection and service delivery, how the resources are being spent and on whom the resources are being spent. The parameters adopted include:

- access to basic health care,
- old age and invalidity pension,
- access to basic education, and
- child benefit.

14 These parameters were adopted after discussion with DFID. The basic parameters fit with those chosen by ILO in a recent draft paper (and with inputs from DFID) entitled 'Can low income countries afford basic social protection?' in which the first results of a modelling exercise targeting sub Saharan Africa were presented.

1.3.3 Service Delivery

15 In the absence of hard data a number of proxies were used to indicate access to services (see the tables in appendix 1). Indicators such as public and private expenditure on health, health personnel per 1000 population, immunisation rates among one year olds, and births attended by skilled health personnel were deemed to be indicators of access to basic health services. These were sourced in the main from World Health Report 2006 or from World Health Statistics 2006. For education, indicators such as gross primary enrolment and the student to teacher ratio were used as indicators, as well as literacy rates and public expenditure per pupil. The data for education were sourced primarily from UNESCO Institute for Statistics 2006 and from World Development Indicators 2006. General social protection indicators, showing availability of statutory benefits, were collected as far as possible for the fragile states using ISSA's Social Security Programs Throughout the World 2004-2005.

1.3.4 Indicators of Need

16 In fragile states, this is probably the most difficult of indicators to access reliably. As proxies for these data, a range of indicators have been used, such as percentage of population of 65 years or older, dependency ratio, life expectancy and the statutory pensionable age (Table A1.8). ISSA's Social Security Programs Throughout the World 2004 – 2005 was the source for most of this data.

1.3.5 Expenditure on Basic Social Protection

17 Expenditures such as ODA grants and humanitarian commitments for health and education were collated, where available, for each of the fragile states, as indicators of what is being spent on service delivery and social protection by the

international community (tables A1.9 and A1.10). These indicators are also notoriously difficult to access, given the different ways different organisations choose to represent their inputs, the different timeframes for financial reporting and planning, and the reluctance of some organisations to quantify inputs to fragile states, since much of the resource is not fed through national authorities. Data for both health and education resource inputs were sourced in part from OECD-DAC International Development Statistics online database; other data were sourced from ReliefWeb's Financial Tracking System of Global Humanitarian Aid, managed by the UN Office for Co-ordination of Humanitarian Affairs.

18 The full range of data reviewed for this work are available as a separate Annex to the report. The consolidated data used are available at Appendix 1, Tables A1.1 – A1.10.

2 Service Delivery Findings

2.1 Health

19 For the purposes of this paper, service delivery for health was assessed based on selected health indicators; mortality rates, ratio of health personnel to population, immunisations among one year olds, and births attended by skilled health personnel (Tables A1.2 and A1.3). These very basic data were seen as indications of the availability of health care to the population and of the accessibility of that health care, since skilled birth attendance and immunisation rates among one year olds would be universally accepted as basic health care.

20 Adult mortality in the fragile states in 2004 ranged from 60 per 1,000 for females in Georgia to 849 for females in Zimbabwe, and 140 for males in Tonga to 667 for males in Central African Republic. Under five mortality showed an equally very wide range, with a low of 14 per 1,000 live births in Dominica to a high of 283 in Sierra Leone.

21 Infant mortality (i.e. death before the first birthday) shows a low of 12 per 1,000 live births also in Dominica to a high of 165 in both Sierra Leone and Afghanistan. Infant mortality is an MDG figure (14) and is used by many of the international aid agencies as a proxy indicator for general nutrition in the population (small low birth weight babies as a result of poor nutrition for the mothers), as well as availability of ante natal services and skilled birth attendance.

22 Maternal mortality (which reflects figures for 2000) are not available for all the fragile states; Dominica, Kiribati, São Tomé, Tonga and Vanuatu are unknown. This raises questions about the validity of the other relatively positive data for Dominica, since maternal mortality figures are commonly collected by all of the NGOs and by central ministries along with other mortality figures. For the countries whose maternal mortality figures are known, Uzbekistan has the lowest at 24 per 100,000 live births, followed by Georgia with 32. The worst maternal mortality appears in Sierra Leone at 2,000 per 100,000 live births, followed by Afghanistan at 1,900. As an MDG indicator (16) maternal mortality figures are now being collected more assiduously than previously. The range of figures for the fragile states indicates very poor performance and, equally, highlights the lack of access to basic health services.

23 While health personnel per 1,000 population is an extremely crude indicator which masks the skewed distribution of personnel within the countries, the figures are useful to the extent that they give some indication of the paucity of personnel. Figures for health personnel (doctors and nurses) were not consistently available for one year, but range from 1996 to 2004. Five countries showed a low of 0.03 doctors per 1,000 population in 2003 and 2004 – Burundi, Ethiopia, Liberia, Niger and Sierra Leone. Chad, Somalia and Togo fared only marginally better, with doctor to population ratios of 0.04. The highest density of doctors to population is in Georgia (in 2003) at 4.09. There were more nurses available per 1,000 population, the lowest

ratio being in Haiti at 0.11 and the highest in Uzbekistan at 9.82. The average of both doctors and nurses in all countries showed a low of 0.21 in Liberia, with a high of 12.56 in Uzbekistan.

24 Immunisation among one year olds showed mixed results. Measles, an MDG indicator (15) showed uptake ranging from a low of 35 percent for Central African Republic and Nigeria, with Lao PDR at 36 percent, and a high of 99 percent in Dominica and Tonga, followed closely by 98 percent in Azerbijan and Uzbekistan. DTP3 vaccination (i.e. the third dose of diphtheria – tetanus – pertussis vaccine) among one year olds showed a low of 25 percent in Nigeria and a high of 99 percent in Dominica, São Tomé, Tonga and Uzbekistan, with Azerbaijan at 96 percent. HepB3 (the third dose of Hepatitis B vaccine) showed significant gaps in data, with 22 countries unaccounted for. Of the others, Papua New Guinea showed the lowest uptake at 45 percent and São Tomé, Tonga and Uzbekistan had the highest uptake at 99 percent.

2.2 Education

25 Enrolment in public and private primary schools – gross enrolment and net enrolment – were taken as proxies for access to primary education, where the data was available (Table A1.4). The ratio of students to teachers was also used, again where it was available, to give an indication of density. As was mentioned for health personnel ratios to population, the student to teacher ratios do not reflect geographical distribution and are of limited value. Literacy rates, public expenditure per primary pupil as a percentage of GDP per capita, and public expenditure on all education as a percentage of GDP were also used as proxies for access (Table A1.5). All available data are referenced to 2004.

26 Gross enrolment rates reflect the numbers of students of any age enrolled in primary school, as a proportion of the total population of primary school age. Therefore the number can be higher than 100, since children older than primary school age can enrol for primary education. However, since the population figures in these countries are not entirely robust and the census figures for children of 5 – 10 years not reliable, the gross primary enrolment is being used as an indicative proxy for access. Net primary enrolment rate suffers the same basic caution of the relevant population group not being clearly determined. However, the net primary enrolment rate is the number of students of primary school age who are enrolled in a primary school, as a proportion of the total population of primary school age. This latter data element is required for MDG 6.

27 The basic data elements of gross enrolment rates and net enrolment rates were not available for Angola, Republic of Congo, Democratic Republic of Congo, Guinea Bissau, Haiti, Liberia, Papua New Guinea, Somalia, Timor Leste and Zimbabwe. The lowest recorded gross enrolment rate (among those countries for which figures are available) is Djibouti at 39 percent and the highest is Sierra Leone at 145 percent. The net enrolment rate shows a low of 33 percent for Djibouti and a high of 98 percent for Cambodia, closely followed by Tajikistan at 97 percent. Of the 46 fragile states, 23 did not have the net primary enrolment figure, a core requirement for reflecting MDG achievement.

28 Student to teacher ratio was unavailable for 17 of the 46 countries. The best reported student to teacher ratio is in Azerbaijan at 14 to one, and the highest ratio is 72 to one in Ethiopia.

29 Literacy rates (i.e. the percentage of people who can read, aged 15 and above) were not available for 21 of the 46 countries. Of those for which data is available the lowest rate is in Mali at 19 percent and the highest are in Azerbaijan, Tajikistan and Tonga, which all report 99 percent. Public expenditure, per primary pupil, as a percentage of GDP per capita was not available for most of the countries. Of the eight countries for which data was available through UNESCO, the lowest expenditure was Cambodia at 6.5 percent and the highest Kenya at 24.7 percent. Public expenditure for all education (across the whole population) as a percentage of GDP was available for 14 countries, the lowest of which is Cambodia at two percent and the highest Cote d'Ivoire at 6.1 percent.

2.3 Other Social Protection Findings

30 Social protection data are available for some social protection benefits in some countries but no country on the fragile states list has data for all four parameters on the limited list of basic social protection provisions identified for the purposes of this paper. The limited list of social protection provisions included old age, disability or survivors pension, cash benefits and medical care for sickness and maternity needs, work injury benefits, unemployment benefits and family or child allowances (Table A1.6). All of the data used were collated from ISSA's Social Security Programs Throughout the World 2004 – 2005.

31 Old age, disability or survivors pensions data were not available for 11 of the 46 countries. Of all the other countries only Burma did not register this pension as a statutory benefit – for any of the types of pensions examined. Data on cash and medical care benefits for sickness and maternity cases were not available for 17 of the countries, which is not to say that such benefits do not exist. Of the countries for which data is available, most countries provide cash benefit only for maternity cases, not for sickness; for medical care, statutory benefits do not exist for six of the countries – Dominica, Ethiopia, Guyana, Solomon Islands, Sudan and Vanuatu. Medical care is available in 22 countries, in seven of which it is limited or provided outside the social security system.

32 As an indicator of need for pension and basic health care (the need for which rises in direct response to age, after the age of 60) the percentage of the population aged 65 or older was used (Table A1.8). Data on over 65s was not available for 11 countries. Of the rest, the percentage elderly population ranged from a low of two percent in Niger, Papua New Guinea and Yemen to a high of 13 percent in Georgia, which is five percentage points higher, then the next highest figure of eight percent in Dominica. Seventeen of the 46 countries report an elderly population of three percent and seven countries of four percent.

33 The types of pension available covered a wide range across countries. A flat rate universal pension – i.e. a pension of uniform amount, normally based on residence but independent of earnings, and generally financed through government contributions – is available only in Nepal. A flat rate pension – i.e. a pension of uniform amount, based on years of service or residence, but independent of

earnings, financed by payroll tax contributions from employees, employers or both is only available in Georgia. Earnings related pensions – i.e. pension based on earnings, financed by payroll tax contributions from employees or employers or both - are more prevalent, available in 25 countries. Means tested pensions – i.e. pensions paid to eligible persons whose own or family income, assets or both fall below designated levels, generally financed through government contributions – are available in Azerbaijan, Georgia, Liberia and Uzbekistan. Provident funds – i.e. employee and employer contributions set aside for each employee in publicly managed special funds, with benefits generally being paid as a lump sum with accrued interest – are available in Indonesia, Kenya, Kiribati, Nepal and Vanuatu. Occupational retirement schemes – i.e. schemes which employers are required by law to provide, financed by employer and, in some cases, employee contributions, with benefits being paid as a lump sum, annuity or pension – are available in Papua New Guinea and the Solomon Islands. Individual retirement schemes i.e. whereby employees and, in some cases, employers must contribute a certain percentage of earnings to an individual account managed by a public or private fund manager chosen by the employee, with the accumulated amounts used to purchase an annuity, make programmed withdrawals, or a combination of the two, and may also be paid as a lump sum – are available only in Nigeria.

3 What is Being Spent on Whom and How?

34 The amounts being spent on basic social protection benefits from all sources are difficult to capture with any degree of reliability. Given the time constraints of this initial piece of work, the expenditures by the 46 governments were not collected: it may be possible to get a picture of this by using base data collected for public expenditure reviews by World Bank teams or by using the ADB's Social Protection Index, briefly described in the next section. For the purpose of this initial work, expenditure on health through international donors and humanitarian funding were used, though these too come with strong cautions. Using a mixture of data sources - OECD-DAC International Development Statistics online database and ReliefWeb's Financial Tracking System of Global Humanitarian Aid, managed by the UN Office for Coordination of Humanitarian Affairs – an outline, no more, has been developed of the magnitude of international assistance for health and education. The figures for ODA and OA grants refer to commitments by the countries of the OECD-DAC, plus others where information is provided to OECD-DAC. They do not reflect actual expenditure. What is included in the label 'basic health' refers to basic health care provision, training of basic health personnel and development of basic health infrastructure, nutrition, infectious disease control, public health campaigns.

35 As an additional caution, experience shows that even the data from international colleague organisations relating to resources spent on health and education, whether by development agencies or humanitarian agencies, have been very difficult to aggregate even when the data collection is undertaken in-country, by the donors themselves.[4/] Moreover, in many instances organisations are not obliged to submit reports on their expenditure to the compiler of the data sets, which means that records may be incomplete: they show a *minimum* figure for what was contributed to a country, but not necessarily the whole sum. This is true for the ReliefWeb database on humanitarian spending which is used in this report.

36 Cautions notwithstanding, some very tenuous pictures can be deduced from the data available for 2004, bearing in mind the geopolitical challenges at the time. A crude way of reviewing the data is to assess the level of commitment per capita for ODA/OA grants to the 46 countries.

37 There is a very wide range of commitment for both health and education across the fragile states. The figures for health are available for all but two (Dominica and Kiribati, the countries with the two lowest population levels) of the 46 fragile states. In health, the lowest level of commitment per capita was to Indonesia, with an amount of $0.04, followed by Guyana at $0.06 and the highest was an astonishing $94.38 for Tonga, with the next highest at $17.01 for Timor Leste. Twenty-seven

4/ The Somalia SACB is a perfect example of this, where it proved impossible for the SACB health sectoral committee to collect or collate all the resource inputs for health by the international community in 2003

countries of the 46 had less than $1 per capita committed to basic health, while 11 countries had between $1.00 and $1.00 per capita committed.

Table 3.1 ODA / OA Grants for Basic Health and Education in 2004

DFID Fragile States	ODA/OA Grants for Basic Health per capita 2004	ODA/OA Grants for Education per Capita for 2004
Afghanistan	No population figures available	No population figures available
Angola	1.71	0.15
Azerbaijan	0.08	0.04
Burma	0.11	0.05
Burundi	0.89	0.19
Cambodia	1.38	0.73
Cameroon	0.27	0.60
Central African Republic	0.78	0.17
Chad	0.69	0.81
Comoros	1.09	0.27
Congo Democratic Republic	0.75	0.86
Congo, Republic of	0.45	2.24
Cote d'Ivoire	0.46	0.11
Djibouti	0.26	0.15
Dominica	….	…
Eritrea	0.95	0.22
Ethiopia	0.47	0.61
The Gambia	0.29	3.77
Georgia	1.91	0.29
Guinea	0.40	0.85
Guinea Bissau	1.30	0.60
Guyana	0.06	0.22
Haiti	0.70	0.88
Indonesia	0.04	0.25
Kenya	1.21	0.43
Kiribati	….	0.79
Lao PDR	1.50	2.06
Liberia	1.84	0.99
Mali	0.85	3.96
Nepal	0.38	4.74
Niger	0.66	1.72
Nigeria	0.17	0.41
Papua New Guinea	3.00	0.04
São Tomé & Principe	1.18	3.39
Sierra Leone	2.64	1.25
Solomon Islands	0.22	12.82
Somalia	0.43	0.63
Sudan	2.06	0.52
Tajikistan	1.11	0.10
Timor Leste	17.01	6.32
Togo	0.41	0.05
Tonga	94.38	1.18
Uzbekistan	0.28	0.03
Vanuatu	1.75	1.78
Yemen, Republic of	0.13	2.95
Zimbabwe	0.24	0.12

38 In education, the lowest commitment recorded was for Uzbekistan at $0.03 per capita, followed closely by Azerbaijan and Papua New Guinea at $0.04 and

Burma at $0.05 per capita. The highest recorded commitment was to the Solomon Islands at $12.82 per capita, with the next highest commitment of $6.32 for Timor Leste, though that was still a lot higher than the third highest of $4.74 for Nepal.

39 There was considerable disparity between the relative amounts per capita committed for health and education. The $17.01 committed for health in Timor Leste was juxtaposed with $6.32 for education per capita, though the commitment to education was still among the highest. In the Gambia, whereas $0.29 was committed to health, $3.77 was committed to education per capita. Conversely, in Georgia, while $1.91 was committed to health per capita, only $0.29 was committed to education. Papua New Guinea showed an even wider disparity, with $3.00 per capita committed to health and only $0.04 (second lowest overall commitment) to education. The widest and inexplicable disparity, however, was in Tonga, with $94.38 per capita committed to health and a 'mere' $1.18 to education (which is still more than the average of the commitments to education at $0.98, when the two largest outliers of $12.82 for Solomon Islands and $6.32 for Timor Leste as well as Dominica, for which figures are not available, and Afghanistan for which population figures are not available, are excluded). Timor Leste had the highest commitment for health per capita and the second highest commitment for education (only surpassed by the relatively huge commitment to education in the Solomon Islands). The average commitment to health (excluding the two highest outliers of Tonga at $94.38 per capita and Timor Leste at $17.01 per capita, Dominica and Kiribati for which no health figures are available, and Afghanistan for which there are no population figures available to make the calculation) was $0.86.

40 These expenditure figures do not, of course, give any indication about precisely where or on whom the resources are being spent, so there is no way to indicate if the resources are being targeted at or reaching the very poorest, or indeed if the resources are being spent effectively, an issue which taxes DFID specifically in relation to fragile states.

41 In terms of humanitarian aid, cash commitment figures for 2004 are available for 27 of the 46 countries. The humanitarian spend, in 14 of these cases, was lower than the amounts committed. However, this does not mean that contributing countries are not adhering to their spending pledges, since there is a time lag between commitment and payment: funds committed in one year may be disbursed in another. Thus, a country that experiences a major disaster or escalation of a crisis, leading to increased humanitarian spend, may have low records of payment in the given year but high levels of commitments: in Haiti, for instance, commitments for humanitarian health projects in 2004 amounted to 20 times the size of actual payments, which probably reflects the increase in support after Tropical Storm Jeanne in 2004. Conversely, a country that is emerging from a crisis may have commitments lower than payments. In Sierra Leone actual expenditure on health in 2004 was $3.2 million but future commitments in that year were much lower, at $1.9 million. Note that this may also be caused by lumpy spending patterns, not just a long-term decline in aid.

42 Although disparities between commitments and actual disbursements may hold little meaning for any particular year, a long-term disparity (i.e. a continued shortfall of payments compared with commitments over several years) may be a useful signal of the incapacity of a country to make use of aid (absorption capacity).

In any case, with these figures, as with those for ODA spending, the bald amounts and comparisons do not help to identify on whom the resources are being targeted or spent, how they are being spent, or how effectively they are being spent.

4 Other Related Findings

4.1 ILO Work on Feasibility of Basic Social Protection

43 The ILO has issued for consultation a draft paper on social protection in sub Saharan Africa: 'Can Low income countries afford basic social protection'. Of the sub Saharan African countries addressed in the ILO work, four are included in the DFID list of fragile states: Cameroon, Ethiopia, Guinea and Kenya. Essentially the findings showed that a basic social protection package (including basic education) can be affordable (using a time span until 2033) (a) if it is made a priority area of national policy, (b) if the share of budgets devoted to social protection is increased from current rates and (c) if international resources can be mobilised. So, ILO asserts, a basic social protection package is within reasonable and affordable limits if countries and donors make a strong commitment to basic social protection as an essential tool of poverty reduction. Clearly the feasibility for this is reduced if the country falls into the DFID unwilling/unable axis.

44 The first modelling by ILO on the feasibility of social protection was followed targeting selected countries in Asia, the draft findings of which were issued for consultation in July 2006, work which was financed by DFID. Of the five countries to which the model was applied, only Nepal falls into the DFID fragile states category. In this second modelling exercise, education was not included in the calculations.

45 However, the findings of both modelling exercises – using three different scenarios of differing national government resource allocation – are broadly consistent and indicate that basic social protection could be an affordable policy option even for poor countries

4.2 ADB's Social Protection Index for Committed Poverty Alleviation

46 The ADB issued, on 9th August 2006, a new index of social protection, which has been systematically applied and tested in six Asian countries and, it is suggested, could be applied to all developing countries. Of the six Asian developing countries represented in the index, two of them – Indonesia and Nepal – fall into the DFID fragile states list. The new social protection index is funded in part by DFID's Poverty Reduction Fund.[5/] The primary objective of the social protection index is to create an internationally applicable algorithm, which will show the variations in social protection coverage and allow qualitative and quantitative analyses of social protection programmes. The time constraints of this initial piece of work did not permit an in depth analysis of the potential applicability of the index to the DFID 46 fragile states, but an initial review shows that the issues covered pertain closely to the needs for targeting the poor in fragile states. Parameters such as poverty targeting, social protection coverage, social protection expenditure and social

5/ Along with the Netherlands's Co-operation Fund in Support of the Formulation and Implementation of National Poverty Reduction Strategies

protection impact are all issues which relate directly to the development of policy for scaling up of assistance to fragile states.

4.3 OECD – DAC's Fragile States Group

47 DFID is already working with other donors to share analysis and understanding of best practice in engagement in fragile states. In January 2005 DFID hosted a senior level forum on development effectiveness in fragile states, co-sponsored by the OECD-DAC, the European Commission, the UNDP and the World Bank. One outcome was the development of a set of 'Principles for Good International Engagement in Fragile States', drafted by the co-chairs of the OECD-DAC's Fragile States Group (FSG) and discussed at the OECD's High Level Meeting of development ministers and heads of donor agencies in March of that year. DFID's Fragile States team continues to work extensively with OECD-DAC in piloting these principles.

5 A Possible Way Forward

48 It is fair to say that much more and better quality information is necessary to directly target the questions raised on behalf of the fragile states: What is being spent on service delivery? How are the resources being spent? And on whom are the resources spent? Defining the actual caseload of those in extreme poverty in fragile states remains projection and supposition if we continue to use traditional means of collecting and analysing data; and the poor co-ordination and data collection mechanisms in place in fragile states mean that information is extremely weak and unreliable about what social protection services and provisions are available. This is the case even in long term aid-dependent states such as Somalia, which has an established aid co-ordination board, through which attempts are made to capture information from all of the donor agencies about inputs in kind and through transfers, but the resulting information is recognised as being of very dubious quality and dubious accuracy.

49 Huge efforts are being invested to address the reduction and alleviation of poverty and the achievement of the MDGs. It is a reasonable assumption that most fragile states will be a sub set of the poorest countries and those which are under-achieving in the MDGs. So, development strategies and policies to address the poorest countries could be adapted to address fragile states, given that many of the characteristics remain similar. In that case, significant synergy could be achieved through collaboration of DFID with the other international work going on – to some of which DFID already contributes.

50 Different branches within DFID are co-operating, collaborating and directly funding the work of the three key players who can provide useful policy background for fragile states, i.e. ADB, ILO and OECD-DAC Fragile States group. The models developed by ILO and the index developed by ADB have now been well tested and have included some of the fragile states in the early testing phases. Indications are that the models and index are at least as reliable for DFID fragile states as they are for states and countries, which are more stable. Having funded and participated in the work involved in both the social protection model of ILO and the social protection index of ADB, it is obvious that DFID should now capitalise on that close involvement and the Fragile States Team is well placed to commission a much more searching piece of work to facilitate policy development for the fragile states. It is proposed that all of the DFID fragile states should be subjected to the rigours of the ILO model and the ADB index. Focusing on the basic social protection benefits would afford DFID a concrete starting point for targeted policy development for fragile states, which would fit with broader policy development for poverty alleviation and achievement of the MDGs and, in turn, contribute to the scaling up of involvement and assistance in fragile states.

51 By using the two mechanisms of the model and the index, the Fragile States Team are helping to develop and expand a consistent approach to aid and development, irrespective of the particular challenges facing states.

52 Using the same base measurements and models would also help to bring together the various related research initiatives within DFID itself, and would help to consolidate approaches and to feed into constructive policy making for the different types of development challenges.

53 Additionally, DFID should encourage the use of both the ILO model and the ADB index to support and progress the work of the OECD-DAC Fragile States Group, in which DFID is also a key participant.

A1 Tables

Table A1.1 General Indicators

	Population[1]	GDP (current US$)	GDP growth (annual %)	GNI per capita, Atlas method (current US$)[2]
Afghanistan	...	5,761,443,000	8	...
Angola	15,490,050	19,492,590,000	11	930
Azerbaijan	8,306,400	8,523,126,000	10	940
Burma	50,003,990	...	...	...
Burundi	7,281,837	657,183,600	6	90
Cambodia	13,798,120	4,884,225,000	8	350
Cameroon	16,037,750	14,390,720,000	4	810
Central African Republic	3,985,971	1,307,439,000	1	310
Chad	9,447,944	4,221,001,000	30	250
Comoros	587,944	366,519,900	2	560
Congo, Dem. Rep.	55,852,890	6,627,668,000	6	110
Congo, Republic of	3,882,947	4,342,923,000	4	760
Cote d'Ivoire	17,871,900	15,474,550,000	2	760
Djibouti	779,102	663,101,200	3	950
Dominica	71,460	271,094,500	2	3,670
Eritrea	4,231,538	924,608,400	2	190
Ethiopia	69,960,840	8,003,289,000	13	110
Gambia, The	1,477,666	415,083,000	8	280
Georgia	4,517,981	5,201,699,000	6	1,060
Guinea	9,201,759	3,869,573,000	3	410
Guinea-Bissau	1,539,712	280,153,200	4	160
Guyana	750,232	785,732,700	2	1,020
Haiti	8,406,941	3,529,829,000	...	...
Indonesia	217,587,500	257,641,500,000	5	1,140
Kenya	33,467,330	16,087,550,000	4	480
Kiribati	97,813	61,939,390	2	970
Lao PDR	5,791,695	2,451,522,000	6	390
Liberia	3,240,578	492,100,000	2	120
Mali	13,124,020	4,862,884,000	2	330
Nepal	26,591,180	6,707,036,000	3	250
Niger	13,498,800	3,081,293,000	1	210
Nigeria	128,708,900	72,053,450,000	6	430
Papua New Guinea	5,771,947	3,908,766,000	3	560
Sao Tome and Principe	152,964	62,251,130	5	390
Sierra Leone	5,336,449	1,075,455,000	7	210
Solomon Islands	465,793	258,125,100	6	560
Somalia	7,964,414	...	...	...
Sudan	35,522,990	21,097,670,000	6	530

	Population[1]	GDP (current US$)	GDP growth (annual %)	GNI per capita, Atlas method (current US$)[2]
Tajikistan	6,430,265	2,073,218,000	11	280
Timor-Leste	924,642	339,000,000	2	550
Togo	5,988,380	2,061,010,000	3	310
Tonga	101,982	212,500,000	4	1,860
Uzbekistan	26,209,060	11,959,870,000	8	450
Vanuatu	207,331	316,353,900	3	1,390
Yemen	20,329,350	12,834,330,000	3	550
Zimbabwe	12,936,300	4,695,914,000	-4	620

Source: World Development Indicators 2006, World Bank. **Reference year:** 2004 for all data. **Symbols:** (...) = data are absent. **Notes:** (1) The World Health Report 2006, WHO, estimates the population of Afghanistan at 28,574,000. (2) See e.g. www.worldbank.org/data/quickreference/quickref.html for an explanation of the Atlas method of calculation.

Table A1.2 Health Indicators – Mortality Rates

	Adult mortality[1]				
	Male	Female	(*) Under-5 mortality[2]	(*) Infant mortality[3]	(*) Maternal mortality ratio[4]
Afghanistan	509	448	257	165	1,900
Angola	591	504	260	154	1,700
Azerbaijan	205	113	90	75	94
Burma	334	219	105	75	360
Burundi	593	457	190	114	1,000
Cambodia	430	276	141	97	450
Cameroon	444	432	149	87	730
Central African Republic	667	624	193	115	1,100
Chad	497	422	200	117	1,100
Comoros	254	182	70	52	480
Congo, Dem. Rep.	576	446	205	129	990
Congo, Republic of	442	390	108	79	510
Cote d'Ivoire	585	500	194	118	690
Djibouti	373	312	126	100	730
Dominica	204	122	14	12	...
Eritrea	345	281	82	52	630
Ethiopia	451	389	166	110	850
Gambia, The	344	263	122	89	540
Georgia	161	60	45	41	32
Guinea	364	319	155	101	740
Guinea-Bissau	482	413	203	126	1,100
Guyana	291	258	64	47	170
Haiti	417	358	117	74	680
Indonesia	239	200	38	30	230
Kenya	477	502	120	78	1,000
Kiribati	297	175	65	49	...
Lao PDR	331	300	83	65	650
Liberia	596	477	235	157	760
Mali	490	414	219	121	1,200
Nepal	297	285	76	59	740
Niger	506	478	259	152	1,600
Nigeria	513	478	197	103	800
Papua New Guinea	322	265	93	67	300
Sao Tome and Principe	301	236	118	75	...
Sierra Leone	579	497	283	165	2,000
Solomon Islands	193	143	56	34	130
Somalia	524	428	225	133	1,100
Sudan	390	304	91	62	590
Tajikistan	166	139	118	91	100
Timor-Leste	267	184	80	64	660
Togo	401	327	140	79	570
Tonga	140	194	25	21	...
Uzbekistan	223	141	69	57	24

	Adult mortality[1]				
	Male	Female	(*) Under-5 mortality[2]	(*) Infant mortality[3]	(*) Maternal mortality ratio[4]
Vanuatu	212	170	40	32	...
Yemen	298	225	111	82	570
Zimbabwe	857	849	129	78	1,100

Source: World Health Statistics 2006, WHO. **Reference year:** Data for adult, under-five and infant mortality rates are for 2004. Maternal mortality ratio data are for 2000. **Symbols:** (...) = data are absent. (*) = indicator is related to an MDG. See notes for further details. **Notes:** (1) Adult mortality rate is the probability of dying per 1,000 population between 15 and 60 years. (2) Under-five mortality rate is the probability per 1,000 live births of a child born in the specified year dying before reaching the age of five if subject to current age-specific mortality rates. This corresponds to MDG indicator no. 13. (3) Infant mortality rate is the probability per 1,000 live births of a child born in the specified year dying before reaching the age of one if subject to current age-specific mortality rates. This corresponds to MDG indicator no. 14. (4) Maternal mortality ratio is the number of maternal deaths during the specified year per 100,000 live births during the same year. This corresponds to MDG indicator no. 16.

Table A1.3 Health Indicators – Access

	Health personnel per 1,000 population[1]				Immunisation among 1-year-olds (%)			(*) Births attended by skilled health personnel (%)[5]	
	Physicians	Nurses	Both	Year	(*) Measles[2]	DTP3[3]	HepB3[4]	%	Year
Afghanistan	0.19	0.22	0.40	2001	61	66	...	14	2003
Angola	0.08	1.15	1.22	1997	64	59	...	47	2000
Azerbaijan	3.55	7.11	10.66	2003	98	96	97	84	2000
Burma	0.36	0.38	0.74	2004	78	82	54	56	1997
Burundi	0.03	0.19	0.22	2004	75	74	83	25	2000
Cambodia	0.16	0.61	0.77	2000	80	85	...	32	2000
Cameroon	0.19	1.60	1.79	2004	64	73	...	62	2004
Central African Republic	0.08	0.30	0.39	2004	35	40	...	44	2000
Chad	0.04	0.27	0.31	2004	56	50	...	14	2004
Comoros	0.15	0.74	0.89	2004	73	76	77	62	2000
Congo, Dem. Rep.	0.11	0.53	0.64	2004	64	64	...	61	2001
Congo, Republic of	0.20	0.96	1.16	2004	65	67	...	...	
Cote d'Ivoire	0.12	0.60	0.73	2004	49	50	50	63	2000
Djibouti	0.18	0.36	0.54	2004	60	64	...	61	2003
Dominica	0.50	4.17	4.67	1997	99	99	...	100	2003
Eritrea	0.05	0.58	0.63	2004	84	83	83	28	2002
Ethiopia	0.03	0.21	0.24	2003	71	80	...	6	2000
Gambia, The	0.11	1.21	1.31	2003	90	92	90	55	2000
Georgia	4.09	3.47	7.56	2003	86	78	64	96	1999
Guinea	0.11	0.55	0.67	2004	73	69	...	35	1999
Guinea-Bissau	0.12	0.67	0.80	2004	80	80	...	35	2000
Guyana	0.48	2.29	2.77	2000	88	91	91	86	2000
Haiti	0.25	0.11	0.36	1998	54	43	...	24	2000
Indonesia	0.13	0.62	0.75	2003	72	70	75	66	2002
Kenya	0.14	1.14	1.28	2004	73	73	73	42	2003

	Health personnel per 1,000 population[1]				Immunisation among 1-year-olds (%)			(*) Births attended by skilled health personnel (%)[5]	
	Physicians	Nurses	Both	Year	(*) Measles[2]	DTP3[3]	HepB3[4]	%	Year
Kiribati	0.30	2.36	2.65	1998	56	62	67	89	2002
Lao PDR	0.59	1.03	1.61	1996	36	45	45	19	2001
Liberia	0.03	0.18	0.21	2004	42	31	...	51	2000
Mali	0.08	0.49	0.57	2004	75	76	73	41	2001
Nepal	0.21	0.22	0.43	2004	73	80	87	11	2001
Niger	0.03	0.22	0.25	2004	74	62	...	16	2000
Nigeria	0.28	1.70	1.98	2003	35	25	...	35	2003
Papua New Guinea	0.05	0.53	0.58	2000	44	46	45	...	
Sao Tome and Principe	0.49	1.55	2.04	2004	91	99	99	79	2000
Sierra Leone	0.03	0.36	0.39	2004	64	61	...	42	2000
Solomon Islands	0.13	0.80	0.92	1999	72	80	72	85	1999
Somalia	0.04	0.19	0.23	1997	40	30	...	34	1999
Sudan	0.22	0.84	1.06	2004	59	55	...	...	
Tajikistan	2.03	4.58	6.61	2003	89	82	81	71	2000
Timor-Leste	0.10	1.79	1.89	2004	55	57	...	24	2002
Togo	0.04	0.43	0.47	2004	70	71	...	49	2000
Tonga	0.34	3.16	3.50	2001	99	99	99	91	2002
Uzbekistan	2.74	9.82	12.56	2003	98	99	99	96	2000
Vanuatu	0.11	2.35	2.46	1997	48	49	56	87	2003
Yemen	0.33	0.65	0.98	2004	76	78	49	22	1997
Zimbabwe	0.16	0.72	0.88	2004	80	85	85	73	1999

Source: Data on health personnel per 1,000 population are from World Health Report 2006, WHO. All other data are from World Health Statistics 2006, WHO. **Reference year:** Data on immunisation are for 2004. All other data are for the years shown in the table. **Symbols:** (...) = data are absent. (*) = indicator is related to an MDG. See notes for further details. **Notes:** (1) 'Physicians' includes generalists and specialists. 'Nurses' includes professional nurses, midwives and other nurses, but excludes traditional birth attendants. 'Both' is the sum of physicians and nurses per 1,000 population. (2) Corresponds to MDG indicator no. 15. (3) 'DTP3' is the third dose of diphtheria-tetanus-pertussis vaccine. (4) 'HepB3' is the third dose of hepatitis B vaccine. (5) Corresponds to MDG indicator no. 16.

Table A1.4 Education Indicators – Primary Enrolment

	Gross enrolment in primary schools (public & private)	Gross enrolment ratio, primary[1]	(*) Net enrolment rate, primary[2]	Student–teacher ratio, primary
Afghanistan	4,430,142	93	...	65
Angola	...	...	...	...
Azerbaijan	607,007	97	84	14
Burma	4,932,646	96	87	32
Burundi	968,488	80	57	51
Cambodia	2,762,882	137	98	55
Cameroon	2,979,011	117	...	54
Central African Republic	(‡) 420,712	(‡) 64	...	...
Chad	(‡) 1,124,992	(‡) 71	...	(‡) 69
Comoros	103,809	85	...	35
Congo, Dem. Rep.	584,370	89	...	83
Congo, Republic of	...	...	...	...
Cote d'Ivoire	...	...	...	...
Djibouti	48,713	39	33	...
Dominica	9,872	(†) 95	(†) 88	19
Eritrea	374,997	66	48	47
Ethiopia	6,489,947	77	46	72
Gambia, The	174,836	81	(‡) 75	37
Georgia	362,582	95	93	...
Guinea	1,147,388	79	64	45
Guinea-Bissau	...	...	...	...
Guyana	(†) 114,161	(†) 129	...	(†) 20
Haiti	...	...	...	...
Indonesia	29,142,093	117	94	20
Kenya	5,926,078	111	76	40
Kiribati	15,611	(†) 115	...	25
Lao PDR	884,629	116	84	31
Liberia	...	...	...	...
Mali	1,396,791	64	46	52
Nepal	4,025,692	114	...	36
Niger	980,033	45	39	44
Nigeria	21,110,707	99	(‡) 60	36
Papua New Guinea	...	...	...	...
Sao Tome and Principe	29,784	133	98	32
Sierra Leone	1,158,399	145	...	(‡) 67
Solomon Islands	87,770	119	80	...
Somalia	...	...	...	...
Sudan	3,208,186	60	...	...
Tajikistan	690,270	100	97	22
Timor-Leste	...	...	...	...
Togo	984,846	101	79	44
Tonga	17,113	115	...	20
Uzbekistan	(‡) 2,440,603	(‡) 100	...	...

	Gross enrolment in primary schools (public & private)	Gross enrolment ratio, primary[1]	(*) Net enrolment rate, primary[2]	Student–teacher ratio, primary
Vanuatu	38,960	118	94	20
Yemen	3,107,801	87	(‡) 75	...
Zimbabwe	...	...	...	...

Source: UNESCO Institute for Statistics, 2006. **Reference year:** 2004 for all data. **Symbols:** (...) = data are absent. (*) = indicator is related to an MDG. See notes for further details. (†) = national estimate. (‡) = estimated by the UNESCO Institute for Statistics. **Notes**: (1) Gross enrolment ratio is the number of students of any age enrolled in primary school as a proportion of the total population of primary-school age. (2) Net enrolment rate is the number of students of primary school age who are enrolled in primary school as a proportion of the total population of primary-school age. This corresponds to MDG indicator no. 6.

Table A1.5 Education Indicators – Other

	Literacy rate (% of people aged 15 and above)	Public expenditure per pupil, primary, as % of GDP per capita	Public expenditure on all education (% of GDP)[1]
Afghanistan	28	...	...
Angola	67	...	...
Azerbaijan	99	...	(‡) 3.3
Burma	90	...	...
Burundi	59	19.9	5.2
Cambodia	74	(‡) 6.5	2
Cameroon	68	...	3.8
Central African Republic	49	...	...
Chad	26	...	...
Comoros	...	...	...
Congo, Dem. Rep.	67	...	...
Congo, Republic of	...	...	...
Cote d'Ivoire	49	...	...
Djibouti	...	...	6.1
Dominica	...	...	...
Eritrea	...	9.8	3.8
Ethiopia	...	...	...
Gambia, The	...	(‡) 7.1	(‡) 1.9
Georgia	...	...	2.9
Guinea	29	...	...
Guinea-Bissau	...	...	...
Guyana	...	(†) 11.7	5.5
Haiti	...	...	...
Indonesia	90	...	...
Kenya	74	24.7	7
Kiribati	...	...	...
Lao PDR	69	...	2.3
Liberia	...	...	...
Mali	19	...	...
Nepal	49	...	...
Niger	29	...	2.3
Nigeria	...	...	...
Papua New Guinea	57	...	...
Sao Tome and Principe	...	...	...
Sierra Leone	35	...	...
Solomon Islands	...	...	...
Somalia	...	...	...
Sudan	61	...	...
Tajikistan	99	(‡) 6.7	2.8
Timor-Leste	...	...	...
Togo	53	...	...
Tonga	99	12.2	4.8
Uzbekistan	...	...	...
Vanuatu	74	...	...

	Literacy rate (% of people aged 15 and above)	Public expenditure per pupil, primary, as % of GDP per capita	Public expenditure on all education (% of GDP)[1]
Yemen	...	...	...
Zimbabwe	...	...	...

Source: Data on literacy rates are from World Development Indicators 2006, World Bank. Data on public expenditure on education are from UNESCO UIS 2006. **Reference year:** 2004 for all data. **Symbols:** (...) = data are absent. (†) = national estimate. (‡) = estimated by the UNESCO Institute for Statistics. **Notes:** (1) Current and capital expenditures on all levels of education by local, regional and national governments. These figures are lower than the figures for public expenditure on primary education per pupil, given in the previous column, since the latter show expenditure per enrolled student while the figures for expenditure on all education are spread across the whole population.

Table A1.6 Social Protection Indicators – Availability of Statutory Benefits

		Sickness / maternity				
	Old age, disability, survivors	Cash benefit	Medical care	Work injury	Unemployment	Family allowances
Afghanistan	...	...	...	...	...	...
Angola	...	...	...	...	...	...
Azerbaijan	✓	✓	✓	✓	✓	✓
Burma	×	✓	✓	✓	...	...
Burundi	✓	...	...	✓	...	✓
Cambodia	...	...	...	...	...	...
Cameroon	✓	†(✓)	✓	✓	...	✓
Central African Republic	✓	†(✓)	(✓)	✓	...	✓
Chad	✓	†(✓)	(✓)	✓	...	✓
Comoros	...	...	...	...	...	...
Congo, Dem. Rep.	✓	×	(✓)	✓	...	✓
Congo, Republic of	✓	†(✓)	(✓)	✓	...	✓
Cote d'Ivoire	✓	†(✓)	✓	✓	...	✓
Djibouti	...	...	...	...	...	...
Dominica	✓	✓	×	✓	...	...
Eritrea	...	...	...	...	...	...
Ethiopia	✓	×	×	✓	...	...
Gambia, The	✓	...	...	✓	...	...
Georgia	✓	†(✓)	✓	✓	✓	✓
Guinea	✓	✓	✓	✓	...	✓
Guinea-Bissau	...	...	...	...	...	...
Guyana	✓	✓	×	✓	...	...
Haiti	✓	...	...	✓	...	...
Indonesia	✓	×	✓	✓	...	...
Kenya	✓	×	✓	✓	...	...
Kiribati	✓	...	...	✓	...	...
Lao PDR	✓	✓	✓	✓	...	...
Liberia	✓	...	...	✓	...	...
Mali	✓	†(✓)	✓	✓	...	✓
Nepal	✓	×	✓	✓	×	...
Niger	✓	†(✓)	✓	✓	...	✓
Nigeria	✓	×	(✓)	✓	(✓)	...
Papua New Guinea	✓	×	✓	✓	...	...
Sao Tome and Principe	✓	✓	(✓)	✓	...	...
Sierra Leone	✓	...	...	...	...	...
Solomon Islands	✓	×	×	✓	(✓)	...
Somalia	...	...	...	...	...	...
Sudan	✓	×	×	✓	...	...
Tajikistan	...	...	...	...	...	...
Timor-Leste	...	...	...	...	...	...
Togo	✓	†(✓)	(✓)	✓	...	✓
Tonga	...	...	...	...	...	...

		Sickness / maternity				
	Old age, disability, survivors	Cash benefit	Medical care	Work injury	Unemployment	Family allowances
Uzbekistan	✓	✓	✓	✓	✓	✓
Vanuatu	✓	×	×	...	...	...
Yemen	✓	...	...	✓	...	...
Zimbabwe	✓	×	✓	✓	...	...

Source: Social Security Programs Throughout the World, 2004–05, International Social Security Association (ISSA). **Reference year:** Asia—latest available information as of March 2005; Africa—latest available information as of September 2005; Americas—latest available information as of March 2006. **Symbols:** ✓ = statutory benefit exists. (✓) = limited support, or support provided outside the social security system. × = statutory benefit does not exist. (...) = data are absent—scheme may or may not exist. † = maternity benefit only, not sickness.

Table A1.7 Types of Old-Age Pension

	Flat-rate universal[1]	Flat-rate[2]	Earnings-related[3]	Means-tested[4]	Provident funds[5]	Occupational retirement schemes[6]	Individual retirement schemes[7]
Afghanistan	...	...	...	...	...	...	...
Angola	...	...	...	...	...	...	...
Azerbaijan	×	×	✓	✓	×	×	×
Burma	×	×	×	×	×	×	×
Burundi	×	×	✓	×	×	×	×
Cambodia	...	...	...	...	...	...	...
Cameroon	×	×	✓	×	×	×	×
Central African Republic	×	×	✓	×	×	×	×
Chad	×	×	✓	×	×	×	×
Comoros	...	...	...	...	...	...	...
Congo, Dem. Rep.	×	×	✓	×	×	×	×
Congo, Republic of	×	×	✓	×	×	×	×
Cote d'Ivoire	×	×	✓	×	×	×	×
Djibouti	...	...	...	...	...	...	...
Dominica	×	×	✓	×	×	×	×
Eritrea	...	...	...	...	...	...	...
Ethiopia	×	×	✓	×	×	×	×
Gambia, The	×	×	✓	×	×	×	×
Georgia	×	✓	×	✓	×	×	×
Guinea	×	×	✓	×	×	×	×
Guinea-Bissau	...	...	...	...	...	...	...
Guyana	×	×	✓	×	×	×	×
Haiti	×	×	✓	×	×	×	×
Indonesia	×	×	×	×	✓	×	×
Kenya	×	×	×	×	✓	×	×
Kiribati	×	×	×	×	✓	×	×

	Flat-rate universal[1]	Flat-rate[2]	Earnings-related[3]	Means-tested[4]	Provident funds[5]	Occupational retirement schemes[6]	Individual retirement schemes[7]
Lao PDR	×	×	✓	×	×	×	×
Liberia	×	×	✓	✓	×	×	×
Mali	×	×	✓	×	×	×	×
Nepal	✓	×	×	×	✓	×	×
Niger	×	×	✓	×	×	×	×
Nigeria	×	×	×	×	×	×	✓
Papua New Guinea	×	×	×	×	×	✓	×
Sao Tome and Principe	×	×	✓	×	×	×	×
Sierra Leone	×	×	✓	×	×	×	×
Solomon Islands	×	×	×	×	×	✓	×
Somalia	...	...	...	...	...	...	...
Sudan	×	×	✓	×	×	×	×
Tajikistan	...	...	...	...	...	...	...
Timor-Leste	...	...	...	...	...	...	...
Togo	×	×	✓	×	×	×	×
Tonga	...	...	...	...	...	...	...
Uzbekistan	×	×	✓	✓	×	×	×
Vanuatu	×	×	×	×	✓	×	×
Yemen	×	×	✓	×	×	×	×
Zimbabwe	×	×	✓	×	×	×	×

Source: Social Security Programs Throughout the World, 2004–05, ISSA. **Reference year:** Asia—latest available information as of March 2005; Africa—latest available information as of September 2005; Americas—latest available information as of March 2006. **Symbols:** ✓ = scheme exists. × = scheme does not exist. (...) = data are absent—scheme may or may not exist. **Notes:** Definitions used by ISSA for the different pension schemes are as follows. (1) Flat-rate universal—pension of uniform amount normally based on residence but independent of earnings, generally financed through government contributions. (2) Flat-rate—pension of uniform amount or based on years of service or residence but independent of earnings, financed by payroll tax contributions from employees, employers, or both. (3) Earnings-related—pension based on earnings, financed by payroll tax contributions from employees, employers, or both. (4) Means-tested—paid to eligible persons whose own or family income, assets, or both fall below designated levels. Generally financed through government contributions, with no contributions from employers or employees. (5) Provident funds: Employee and employer contributions are set aside for each employee in publicly managed special funds. Benefits are generally paid as a lump sum with accrued interest. (6) Occupational retirement schemes—employers are required by law to provide private occupational retirement schemes financed by employer and, in some cases, employee contributions. Benefits are paid as a lump sum, annuity, or pension. (7) Individual retirement schemes—employees and, in some cases, employers must contribute a certain percentage of earnings to an individual account managed by a public or private fund manager chosen by the employee. The accumulated capital in the individual account is used to purchase an annuity, make programmed withdrawals, or a combination of the two and may be paid as a lump sum.

Table A1.8 Social Protection – Indicators of Need

			Life expectancy		Statutory pensionable age	
	Population aged 65 or older (%)	Dependency ratio[1]	Male	Female	Male	Female
Afghanistan	...	...	...	...	...	...
Angola	...	...	...	...	...	...
Azerbaijan	7	56	69	76	62	57
Burma	5	61	54	59	n/a	n/a
Burundi	3	102	40	41	60	60
Cambodia	...	...	...	...	...	...
Cameroon	4	88	49	51	60	60
Central African Republic	4	89	43	46	55	50
Chad	3	98	45	48	55	55
Comoros	...	...	...	...	...	...
Congo, Dem. Rep.	3	107	51	53	65	60
Congo, Republic of	3	98	50	54	55	55
Cote d'Ivoire	3	83	48	48	55	55
Djibouti	...	...	...	...	...	...
Dominica	8	56	71	77	60	60
Eritrea	...	...	...	...	...	...
Ethiopia	3	93	43	44	60	60
Gambia, The	3	77	46	49	55	55
Georgia	13	50	70	78	65	60
Guinea	3	88	48	49	55	55
Guinea-Bissau	...	...	...	...	...	...
Guyana	5	53	62	68	60	60
Haiti	4	71	53	54	55	55
Indonesia	5	55	65	69	55	55
Kenya	3	86	49	50	55	55
Kiribati	3	74	58	64	50	50
Lao PDR	4	86	53	56	60	60
Liberia	3	84	55	57	60	60
Mali	4	101	51	53	58	58
Nepal	4	81	60	60	55	55
Niger	2	108	46	47	60	60
Nigeria	3	93	52	52	50	50
Papua New Guinea	2	74	57	59	55	55
Sao Tome and Principe	4	105	65	69	62	57
Sierra Leone	3	89	39	42	60	60
Solomon Islands	3	90	68	71	50	50
Somalia	...	...	...	...	...	...
Sudan	3	77	56	58	60	60
Tajikistan	...	...	...	...	...	...
Timor-Leste	...	...	...	...	...	...
Togo	3	90	51	53	55	55
Tonga	...	...	...	...	...	...

			Life expectancy		Statutory pensionable age	
	Population aged 65 or older (%)	Dependency ratio[1]	Male	Female	Male	Female
Uzbekistan	5	69	67	73	60	55
Vanuatu	3	83	68	71	55	55
Yemen	2	110	61	63	60	55
Zimbabwe	3	94	43	42	60	60

Source: Social Security Programs Throughout the World, 2004–05, International Social Security Association. **Reference year:** Asia—latest available information as of March 2005; Africa—latest available information as of September 2005; Americas—latest available information as of March 2006. **Symbols:** (...) = data are absent. **Notes:** (1) Population aged 14 or younger plus population aged 65 or older, divided by population aged 15–64.

Table A1.9 Expenditure on Health – International Donor and Humanitarian Funding

	ODA / OA grants for basic health ($)[1]	Humanitarian[2]			
		Commitment (cash)	Paid (cash)	Commitment (in kind)	Paid (in kind)
Afghanistan	108,188,000	6,355,284	746,269	…	…
Angola	26,525,000	6,325,224	6,521,509	…	…
Azerbaijan	732,000	…	…	…	…
Burma	5,480,000	10,070,200	6,170,327	…	…
Burundi	6,505,000	94,640	…	…	…
Cambodia	19,015,000	68,526	…	…	…
Cameroon	4,395,000	...	1,294,210	…	…
Central African Republic	3,139,000	7,949,978	2,592,279	…	…
Chad	6,534,000	...	…	…	…
Comoros	642,000	1,357,678	…	…	…
Congo, Dem. Rep.	42,069,000	44,581,929	1,324,385	…	…
Congo, Republic of	1,734,000	8,134,032	970,000	…	…
Cote d'Ivoire	8,204,000	60,976	100,000	…	…
Djibouti	207,000	…	…	…	…
Dominica	...	770,000	3,795,547	…	…
Eritrea	4,036,000	2,208,115	…	…	…
Ethiopia	32,707,000	9,146	…	…	…
Gambia, The	435,000	…	…	…	…
Georgia	8,625,000	135,000	1,206,785	…	…
Guinea	3,658,000	246,305	...	50,891	
Guinea-Bissau	1,944,000	…	…	…	…
Guyana	44,000	6,973,381	2,424,048	1,488,095	...
Haiti	5,875,000	4,297,293	215,874	345,252	23,108,864
Indonesia	9,082,000	905,795	…	…	…
Kenya	40,505,000	…	…	…	…
Kiribati	...	…	…	…	…
Lao PDR	8,679,000	23,663,526	2,567,393	…	…
Liberia	5,965,000	...	75,000	…	…
Mali	11,159,000	3,527,314	…	…	15,000
Nepal	10,032,000	702,855	…	…	
Niger	8,901,000	...	...	...	...
Nigeria	22,426,000	407,780	…	…	…
Papua New Guinea	17,325,000	...	…	…	…
Sao Tome and Principe	182,000	…	…	…	…
Sierra Leone	14,078,000	1,915,203	3,225,294	…	…
Solomon Islands	104,000	…	…	…	…
Somalia	3,400,000	10,784,227	5,201,480	332,000	…
Sudan	32,889,000	66,789,562	28,244,220	153,334	…
Tajikistan	7,160,000	4,325,733	3,746,503	…	…
Timor-Leste	15,732,000	…	…	…	…
Togo	2,436,000	…	…	…	…
Tonga	9,625,000	…	…	…	…

	ODA / OA grants for basic health ($)[1]	Humanitarian[2]			
		Commitment (cash)	Paid (cash)	Commitment (in kind)	Paid (in kind)
Uzbekistan	7,262,000	...	...	...	...
Vanuatu	364,000	...	...	...	...
Yemen	2,570,000	...	...	...	...
Zimbabwe	3,089,000	1,937,177	1,283,433	...	...

Source: Data on ODA / OA grants are from OECD-DAC International Development Statistics online database. Data on humanitarian funding are from ReliefWeb's Financial Tracking System of Global Humanitarian Aid, managed by the UN Office for Coordination of Humanitarian Affairs. **Reference year:** 2004 for all data. **Symbols:** (...) = data are absent. **Notes:** (1) Official development assistance (ODA) and official aid (OA). These are commitments, not actual expenditure. Data covers grants committed by the countries of the OECD-DAC, plus others where information is provided to OECD-DAC. 'Basic health' refers to basic health care provision, training of basic health personnel and development of basic health infrastructure; nutrition, infectious disease control, public health campaigns. (2) 'Commitment' = funds for which donors signed contracts in 2004 to authorise disbursement (these commitments may not have been spent in that year, or even at all). 'Paid' contribution = funds transferred from the donor to an agency in 2004 as a result of a commitment (the commitment may have been made in a previous year). Data are provided by donors and agencies and may not be complete. Definition of humanitarian spending on health covers a range of health-related activities during a crisis or its aftermath—see http://ocha.unog.ch/fts/exception-docs/AboutFTS/FTS_criteria_for_posting_ contributions.pdf.

Table A1.10 Expenditure on Education – International Donor and Humanitarian Funding

	ODA / OA grants for basic education ($)[1]	Humanitarian[2]			
		Commitment (cash)	Paid (cash)	Commitment (in kind)	Paid (in kind)
Afghanistan	134,263,000	1,470,602	…	…	…
Angola	2,405,000	334,350	…	…	…
Azerbaijan	338,000	…	…	…	…
Burma	2,608,000	262,111	…	…	…
Burundi	1,442,000	…	…	…	…
Cambodia	10,024,000	…	…	…	…
Cameroon	9,591,000	937,000	…	…	…
Central African Republic	680,000	…	…	…	…
Chad	7,686,000	…	…	…	…
Comoros	162,000	…	…	…	…
Congo, Dem. Rep.	48,233,000	2,201,735	…	…	…
Congo, Republic of	8,682,000	6,137,792	…	…	…
Cote d'Ivoire	2,016,000	…	…	…	…
Djibouti	119,000	…	…	…	…
Dominica	…	72,000	…	…	…
Eritrea	949,000	…	…	…	…
Ethiopia	42,455,000	…	…	…	…
Gambia, The	5,570,000	…	…	…	…
Georgia	1,298,000	…	…	…	…
Guinea	7,860,000	…	…	…	…
Guinea-Bissau	919,000	…	…	…	…
Guyana	163,000	636,132	…	…	…
Haiti	7,387,000	618,869	…	…	…
Indonesia	54,135,000	…	…	…	…
Kenya	14,391,000	…	…	…	…
Kiribati	77,000	…	…	…	…
Lao PDR	11,964,000	…	…	…	…
Liberia	3,197,000	…	…	…	…
Mali	52,004,000	…	…	…	…
Nepal	126,007,000	…	…	…	…
Niger	23,219,000	123,750	…	…	…
Nigeria	52,778,000	…	…	…	…
Papua New Guinea	230,000	…	…	…	…
Sao Tome and Principe	518,000	…	…	…	…
Sierra Leone	6,689,000	185,323	…	…	…
Solomon Islands	5,970,000	…	…	…	…
Somalia	5,075,000	3,678,769	…	…	…
Sudan	18,412,000	5,675,717	…	…	…
Tajikistan	651,000	…	…	…	…
Timor-Leste	5,846,000	…	…	…	…
Togo	332,000	…	…	…	…
Tonga	120,000	…	…	…	…

	ODA / OA grants for basic education ($)[1]	Humanitarian[2]			
		Commitment (cash)	Paid (cash)	Commitment (in kind)	Paid (in kind)
Uzbekistan	797,000	...	...	...	...
Vanuatu	370,000	...	...	...	...
Yemen	60,003,000	...	...	...	...
Zimbabwe	1,527,000	196,000	...	...	...

Source: Data on ODA / OA grants are from OECD-DAC International Development Statistics online database. Data on humanitarian funding are from ReliefWeb's Financial Tracking System of Global Humanitarian Aid, managed by the UN Office for Coordination of Humanitarian Affairs. **Reference year:** 2004 for all data. **Symbols:** (...) = data are absent. **Notes:** (1) Official development assistance (ODA) and official aid (OA). These are commitments, not actual expenditure. Data covers grants committed by the countries of the OECD-DAC, plus others where information is provided to OECD-DAC. 'Basic education' refers to primary, basic life skills for youth and adults and early childhood education. (2) 'Commitment' = funds for which donors signed contracts in 2004 to authorise disbursement (these commitments may not have been spent in that year, or even at all). 'Paid' contribution = funds transferred from the donor to an agency in 2004 as a result of a commitment (the commitment may have been made in a previous year). Data are provided by donors and agencies and may not be complete. Definition of humanitarian spending on education covers a range of activities in schools and other facilities, and support toduring a crisis or its aftermath—see http://ocha.unog.ch/fts/exception-docs/AboutFTS/FTS_criteria_for_posting_contributions.pdf.

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