

A rethink on the use of aid mechanisms in health sector early recovery

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List of Abbreviations

CPA	Comprehensive Peace Agreement
CPIA	Country Policy and Institutional Assessment
DAC	Development Assistance Coordination
DFID	Department for International Development (United Kingdom)
EC	European Commission
ECHO	European Commission Humanitarian Office
EDF	European Development Funding
EU	European Union
FBO	Faith Based Organisation
GBS	General Budget Support
GoSL	Government of Sierra Leone
GoSS	Government of South Sudan
IMF	International Monetary Fund
MDBS	Multi Donor Budget Support
MDG's	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MoF	Ministry of Finance
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
NHA	National Health Account
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OFDA	Office of U.S. Foreign Disaster Assistance
PAF	Performance Assessment Framework
PFM	Public Financial Management
PRSP	Poverty Reduction Strategy Paper
SS	South Sudan
TA	Technical Assistance
UN	United Nations
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Acknowledgement

A recent paper on service delivery in fragile states (OECD, 2008) acknowledges that the international community is increasingly engaging in conflict affected states, while recognising that these situations require sustained attention and tailored approaches. This sentiment resonates with our own personal findings while working in conflict and early recovery contexts over the past decades. Bridging humanitarian and development efforts require carefully designed strategies to ensure continuity of support to a country emerging from protracted crises. Central to the success of this engagement is the choice of aid mechanisms to deliver the much needed resources for delivery of essential services and for institutional development of a health sector under reconstruction. This paper is a product of an enquiry conducted with international agencies and governments in a number of post conflict countries, in an endeavour to explore the use of different aid mechanisms deployed and their contribution to early recovery efforts in the health sector.

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Executive Summary

Working in fragile states requires new strategies of engagement between governments and donors to improve aid effectiveness for the health sector. Aid to the health sector in settings that are recovering from conflict is often typified as addressing the tension between the (often conflicting) aims of immediate life saving and systems building. In addition, the early recovery phase is marked by differing degrees of partnering with the state. This can imply adopting a state-avoiding approach through humanitarian relief focusing on service delivery, or a more developmental approach whereby the state is seen as a partner with the primary aim of health systems building. This calls for more attention to the question of how aid mechanisms can effectively contribute to maintaining an uninterrupted resource flow during the transition from humanitarian to development aid, and how they can address the dual objectives of ensuring basic health services delivery while simultaneously building health sector systems.

Based on experiences and findings from four case study countries (Liberia, Southern Sudan, Sierra Leone, Timor Leste), we have found that aid effectiveness can be improved during early recovery once we recognise that it is no longer applicable to gradually move from the use of traditionally “humanitarian” aid mechanisms to those which are conventionally considered “developmental”. Instead, early recovery systems require flexible solutions and experimentation where different objectives (service delivery, system building) and delivery modes (state, non-state) are creatively combined or used in parallel. This is more likely to be achieved by an appropriate mix and sequencing of aid mechanisms rather than by a singular approach. Management arrangements and design features of aid mechanisms undoubtedly influence aid effectiveness. This is even more crucial in early recovery settings, where government capacity tends to be weaker and more fragile, the change efforts are more complex, and financing needs can change quickly. Greater coordination in the choice and deployment of aid mechanisms while capitalising on relevant donor comparative advantages with particular regard to technical expertise in certain policy areas and /or operational procedures during early recovery is therefore recommended.

1 Introduction

Since the signing of the Paris Declaration in 2005, enhancing aid effectiveness has played an increasingly central role in the international development arena. The Declaration promotes the use of aid effectiveness principles such as ownership, alignment, harmonisation, mutual accountability and managing for results (OECD DAC, 2005c). A more recent impetus towards this goal is derived from the “Third High Level Forum on Aid Effectiveness” held in Accra in September 2008. Building on the agreed principles of aid effectiveness for the health sector, the International Health Partnership⁴ was established in September 2007 with the aim to work towards the achievement of the Millennium Development Goals (MDG’s), through the strengthening of national health systems and improved health results.

Achieving the MDGs and other global targets may be feasible where functional systems are in place and where governments are committed to commonly agreed policies and strategies to achieve the goals. Fragile states contexts however meet with major deficits in their capacities to deliver against such ambitious global targets. Fragile states have been defined in many different ways by different actors; generally highlighting the limited willingness and/or capacity of the state to provide services (DFID, 2005). The extent of fragility today is evident; with over one billion of the world’s six billion people now living in fragile states, and one third of all people surviving on less than USD 1 per day. Of all the children in the world who die before reaching their fifth birthday, half were born in these countries. Of all the women whose deaths are related to pregnancy or childbirth, one in three dies in fragile states (OECD DAC, 2007).

Early recovery is most often characterised by the existence of weak institutions and governance systems with a fundamental lack of leadership, state capacity and/or political will to fulfil essential state functions, especially in terms of providing basic services to the poor (World Bank, 2008). For the purpose of this paper, we have adopted the definition as developed by the Early Recovery Cluster Working group (2008):

‘...a multidimensional process of recovery that begins in a humanitarian setting. It is guided by development principles that seek to build on humanitarian programmes

⁴ International Health Partnership Launch, September 05, 2007 - with initial funding from DFID and NORAD.

and catalyze sustainable development opportunities. It aims to generate self sustaining, nationally owned, resilient processes for post crisis recovery.’

Special attention is required to discern more effective strategies for working with countries emerging from conflict. A previous paper by two of the authors (Canavan, Vergeer, et al, 2008) concluded that the transition from humanitarian relief to development assistance to the health sector is frequently affected by the choice of aid mechanism deployed. Aid mechanisms as a means of delivering the financial and technical resources to a country were found to be a major determinant for achieving continued delivery of health services and the desired impact of strengthened health systems to improve people’s health status. These observations stimulated further exploration.

This paper therefore examines the use of selective aid mechanisms in the context of early recovery of health systems. By drawing on experiences from a range of post conflict countries (Liberia, Southern Sudan, Timor-Leste and Sierra Leone), we assess the strengths and weaknesses of the different aid mechanisms. We aim to determine how well specific aid instruments serve early recovery efforts in the health sector in a particular context and what could be done to further improve aid effectiveness. The case studies are based on visits to the countries by the authors (Sierra Leone, Liberia and Timor-Leste) or on direct interviews with key informants and use of secondary data sources in the case of Southern Sudan.

2. Aid to fragile states

Fragile states have been systematically under-aided in the sense that they received less aid per capita than is identified based on the Country Policy and Institutional Assessment (CPIA) score⁵ (DFID, 2005), and as shown by OECD/DAC (2005a) research investigating aid allocation levels between 1992 and 2002.

Since 2000 however, Official Development Assistance (ODA) levels to fragile states have increased significantly, from \$5.8 billion in 2000 to \$26.8 billion in 2006 which has in fact exceeded overall growth in ODA during the same period. An increasing focus on fragile states by the international development community is justified on the basis of human development peril and the growing threats of regional and global insecurity. While acknowledging under-aided states, it is equally important to recognise the disproportionate aid allocation within the fragile state context whereby 75% of ODA is dedicated to a total of 38 fragile states in 2006, with five countries benefiting most. These 'aid darlings' included Afghanistan, DRC, Nigeria, Sudan, and Cameroon, which were in sharp contrast to aid levels to 'aid orphans' such as Myanmar or Congo Republic (Brazzaville) (OECD DAC, 2007).

With regard to the health sector in fragile states and more specifically in the context of early recovery, we are witnessing mixed results in terms of aid volume and predictability of aid flow. The transition funding study (Canavan, Vergeer, et al, 2008), commissioned by the Health and Fragile States Network demonstrates that it is difficult to assess the net volume of funds allocated due to poor fiscal tracking in many post conflict countries. The study furthermore revealed that the transition from humanitarian relief to development assistance to the health sector is affected by a range of determinants including, donor policies and behaviour, government legitimacy and also the choice of aid mechanism deployed. Specific country examples are selected here to explore the effects of some of the aid mechanisms used in the immediate post conflict years;

During the immediate early recovery phase (2005-07), *Southern Sudan* faced a closure of Non Governmental Organisation (NGO) projects and manifestations of a plateau in primary health services while a decline in secondary healthcare was apparent, if

⁵ CPIA scores divide low-income countries into five categories of performance, the lowest two of which are useful proxies for state fragility. There is a separate group of unranked countries, also deemed fragile. This provides a list of 46 fragile states, containing 870 million people or 14% of the world's population.

compared to service coverage during the conflict. The MDTF mobilised resources and funding commitment for early recovery. However, delays were experienced in its operationalisation.

Meanwhile, *Liberia* faced an imminent gap in health service delivery during early recovery due to a delay in the availability of development funding, which was averted by an extension of humanitarian project aid. Levels of funding to the health sector increased following an initial decline, with aid commitments growing from \$36 million (2005) to \$77 million (2008), and overall trends showing a shift to longer term development funding from 2007 onwards.

Sierra Leone witnessed a downsizing in humanitarian support to health services following the 2002 peace agreement, while development funds were slow to arrive. Increased commitments to meeting MDG 4 and 5 have more recently mobilised aid to deliver the national Reproductive and Child Health strategic plan (2008-10), by multilateral and bilateral donors in direct collaboration with the Ministry of Health. Overall, anecdotal evidence has indicated gaps in primary health services, due to the departure of humanitarian funded NGOs, during the early recovery phase.

Timor-Leste's health system needed to be rebuilt following independence from Indonesia in 2002, as 35% of the health facilities had been destroyed during the withdrawal of militia's after the elections. Initially, humanitarian aid continued through support from NGOs for health service delivery; later replaced by district provision of health services through support from developmental aid modalities, i.e. the Multi Donor Trust Fund for East Timor managed by the World Bank. Retrospective data indicates large fluctuations in per capita health expenditure during the immediate post conflict period, but there was no net financial gap during the early recovery of the health sector due to large donor 'buy in'.

3. Approaches to health sector support in early recovery

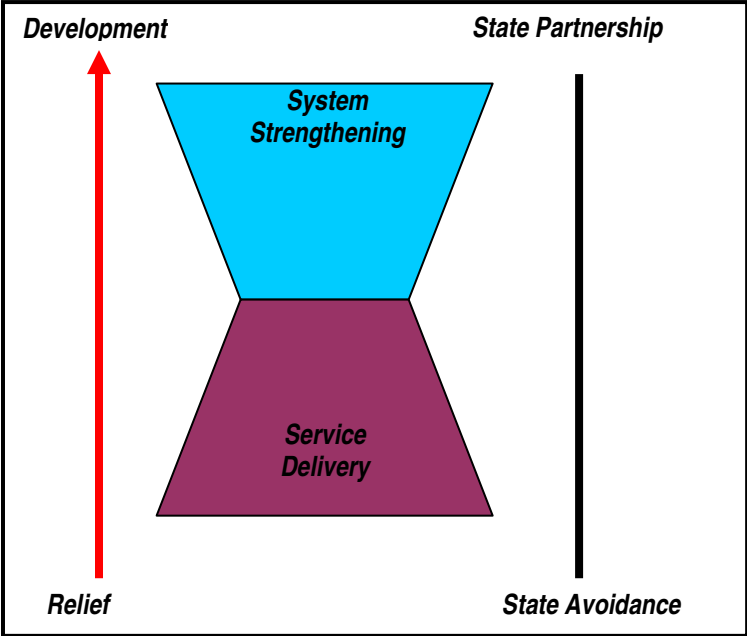
Times of conflict and recovery witness inordinate levels of morbidity and mortality, especially amongst the most vulnerable; women and children. People's increased vulnerability is frequently caused by enforced relocation, lack of basic needs (food, shelter), and corresponding lack of essential services. During early recovery, the health system is not able to respond to the overwhelming needs of its populations. The complexity of the support to the health sector during early recovery should not be underestimated as creating and sustaining population health while simultaneously managing, financing and governing the health system are major challenges, as identified by the World Health Organization in their address to Aid effectiveness and Health. (WHO, 2007)

Newbrander (2007) and Waters, et al (2007) describe how the health system is often characterized by a weak health infrastructure with insufficient facilities, equipment and supplies. The organisation and management of the health system is often dysfunctional while a vacuum exists, both in regards to policy and service delivery. Weak information hinders the development of evidence based policies or the promotion of equitable and accessible health care for all. Gaps in health provider and management capacities create a hiatus in the early recovery efforts with continued reliance on NGOs for basic health services provision. Such a traditionally "humanitarian" approach is service delivery focused and by implication is state avoiding. But strengthening the capacity and developing the systems and processes to enable government to assume leadership is also vital. Waldman (2006) highlights that it can be a powerful peace dividend when government become more effective in carrying out its role in the health sector, whereas improving accountability will enhance the legitimacy of government. Such a development approach requires partnership with the state. However, limitations to government absorptive capacity can determine the degree of working within or outside state (Taylor, 2005).

During the early recovery phase, continuity of health service delivery is required concurrent with health system strengthening. On the other hand, donor support follows a more linear continuum; with aid mechanisms progressively advancing from a humanitarian approach which is more state-avoiding in nature to a developmental approach promoting state-partnership, as demonstrated in *Figure 1*.

We therefore question to what extent the aid mechanisms used serve the early recovery efforts in the health sector; which we explore through a case study approach in chapter 4.

Figure 1. Relief to development continuum



4. Aid mechanisms in early recovery

Working in early recovery contexts calls for innovative approaches and adjustment to the traditional way of working. This chapter will investigate the use of a variety of aid mechanisms and their contribution to continued health service delivery and to health sector strengthening in specific early recovery contexts, as presented in *figure 1*. While it is recognised that multiple aid mechanisms may be in use in the particular countries, the main aim is to explore how specific aid mechanisms serve the early recovery efforts in the health sector. The selected aid mechanisms studied here include;

- General Budget Support in Sierra Leone,
- Multi-Donor Trust Fund in South Sudan,
- Extension of humanitarian aid in Liberia as an example of project aid in a non-governmental context, and
- Technical Assistance, as an example of project aid to build the capacity of Timor-Leste's government.

4.1 General Budget Support in Sierra Leone

4.1.1 Definitions

Budget support refers to external financial assistance provided directly to the treasury of a partner country and managed in accordance with the country's own financial systems and budget procedures. Budget support would be classified according to the objectives set of 'systems building' and 'state engagement', with the ultimate aim to strengthen government capacity to deliver efficient and effective public services to the poor.

Budget support has become the preferred aid modality for many donors in particular in more stable developing country environments (OECD DAC, 2006). But it is not a traditional choice of aid modality in a post-conflict environment. Donors are risk averse and tend to avoid budget support in fragile contexts, because these countries are characterised by severely limited fiscal capacity, unstable macro-economic environments and high fiduciary risks. Commonly, the provision of budget support presupposes government commitment to poverty reduction, relative macro-economic stability and a functioning Public Financial Management (PFM) system which can assure the proper use of funds for poverty reduction purposes. If the latter is not in place, alternatively a reform programme which credibly addresses fiduciary risks and to which strong government

commitment exists, is considered acceptable. These eligibility criteria are seldom fulfilled in early recovery environments, in particular a sound PFM system.

4.1.2. Lessons learned

In February 2002, the Sierra Leone People's Party government declared peace after a ten year period war followed by successful collaboration between the government and the international community which has stabilized the security situation and put an end to widespread violence and fear.

General budget support (GBS) to Sierra Leone has been provided immediately after the ending of the conflict in 2001 by a Multi-Donor Budget Support (MDBS) Group consisting of DFID, World Bank (WB), European Commission (EC), and the African Development Bank. The main purpose of the GBS operation was to promote a stable macro-economic environment, poverty reduction through improved service delivery and a more effective and accountable government, thereby contributing to maintaining peace and security.

GBS, a brave leap of faith

The provision of budget support was clearly a brave leap of faith as Sierra Leone was one of the first fragile states to receive this aid modality. During the early years of the budget support operation (2001-04), the Government of Sierra Leone (GoSL) had not yet built up a solid track record that would lead to qualifying for budget support. Yet, commitment to reform was there: GoSL was on track with the Poverty Reduction Growth Facility programme of the International Monetary Fund (IMF) and committed to increased spending on poverty reduction. An Interim-Poverty Reduction Strategy Paper (PRSP) was prepared in 2001 and a full PRSP finalized in 2005. PFM capacity was weak but diagnostic studies generated a better understanding of the strengths and weaknesses and informed the design of capacity building programmes. Risk mitigation measures were put in place through governance reform efforts (i.e. anti-corruption, accountability) targeting the weaknesses in the system, to ensure enhanced fiduciary measures.

GBS contributed to macro-economic stability but undermined fiscal management

Budget support may matter because of its stabilizing force on macro-economic management, reinstating trust into a long-term partnership between the GoSL and the

international community, and providing an anchor for more coordinated aid programmes. GBS in Sierra Leone has positively impacted macro-stability and economic growth by bringing in significant funding to the government budget. It has provided a focal point for policy dialogue on a common reform agenda between GoSL and its development partners, thereby boosting political and business confidence in a nascent nation. Yet, budget support has undermined fiscal management due to significant disbursement delays and unpredictability in the size of funding between 2003 and 2006. This has caused an increase in domestic borrowing and inflation crowding out private sector investment.

GBS increased social spending, although limited for health

GBS has been a very important source of government financing, in particular of pro-poor expenditures, in the post-conflict period. As share of total resources over which the government has a real choice⁶, GBS has exceeded 26% between 2002 and 2007, with the exception of 2003 (Lawson, 2007). GBS would only exceed this figure in Mozambique, Tanzania and Uganda, which are the most “mature” of current GBS receiving countries. GBS (in combination with HIPC debt relief) has widened the fiscal space in Sierra Leone, leading to a steady spending increase in education (between 18-22% of total recurrent spending). The share of health has risen from 4% in 2001 to 8% of total recurrent spending in 2003 but has declined to around 6% since (Lawson, 2007). The precise reason for this decline in the budget allocation requires further exploration, but has been beyond the scope of this paper. Currently a decentralized health system is in place with over 40% of district based services supplied by NGO’s, and the National Health Account (MoH Sierra Leone, 2007) revealed high out of pocket expenditures in 2006. While GBS has increased the size of spending on pro-poor service delivery (to a lesser extent in health), there is little evidence that at the same time the quality of the services provided has been significantly strengthened.

In early recovery situations where the urge for basic social services is high, not least due to the need for a visible peace dividend, earmarking of budget support can help to safeguard a certain level of funding to health sector budgets. Budget support will, however, not be the magic bullet to solving problems with funding, government capacity, aid management and service delivery simultaneously – also not to health sector challenges. A much more realistic view of what budget support can achieve given

⁶ As measured as the proportion of domestically financed expenditures and discretionary recurrent expenditure (excluding interest payments).

individual country circumstances is needed in order not to overstretch objectives and expectations on effectiveness. Given major capacity constraints at sector level in Sierra Leone, GBS can not substitute for the systematic lack of policy dialogue and capacity in planning, budgeting, implementation, and monitoring at sector level. An appropriate mix of aid modalities could arguably more effectively address this challenge. To this end, Sector Budget Support and other sector financial aid (e.g. pooled funds) may prove useful alongside general budget support to develop deeper sector dialogue on policy and institutional strengthening.

GBS strengthened PFM systems at central level but less so at sector level

Through the focus on accompanying technical assistance in the area of PFM and governance, budget support has become an important instrument of capacity building. Strengthening PFM systems is crucial to make sure that funds reach the service delivery level. Public Expenditure Tracking Surveys have been instrumental in monitoring budget execution processes in the absence of strong routine accounting and monitoring systems. GBS conditionality has furthermore helped to promote important reforms in the area of PFM in particular at central agency and oversight level but much remains to be done; reforms are still at an early stage focusing on an appropriate legal and regulatory regime and, in many cases, new procedures and systems have yet to be actually implemented. There also needs to be greater focus on capacity building at sector level.

GBS improved aid effectiveness but conditionality approach is not in line with international best practices

Budget support is considered a welcome stimulus to promoting government ownership and a common platform for broad and systematic policy dialogue around a shared policy agenda focussing on poverty reduction, in addition to facilitating joint monitoring efforts across the whole of government (DFID EVD, 2008). The move towards budget support in Sierra Leone has certainly improved coordination between donors and with government. Donors have increasingly coordinated policy dialogue in the context of the MDDBS group and successively harmonised funding disbursement by using a common Performance Assessment Framework (PAF). However, experience has also illustrated that the conditionality approach has not always been in line with latest international best practices. Conditionality cannot buy reforms. Attempting to micro-manage the reform process and using conditionality as a stick rather than an agreed set of milestones between

partner government and donors has sometimes undermined government ownership of the reform agenda. The number of indicators used in the MDDBS PAF remains high, risking that regular monitoring and evaluation become unmanageable and as a result meaningless. Donors have used in-year conditionality, and a common response mechanism is not yet in place. Each donor tends to have its own arrangements to respond gradually to the government's performance- depending on the individual donors risk mitigation strategy (e.g. different indicators triggering disbursement).

Funding through GBS has been volatile and unpredictable

Aid volatility induced by MDDBS in Sierra Leone has been another concern. Disbursement of budget support resources has been highly unpredictable leading to significant shortfalls in government funding. GBS disbursements have at times been as low as 60% of commitments and as late as the fourth quarter of the recipient government fiscal year (OPM, 2006). This has resulted in the expansion of domestic borrowing and the creation of substantial new debt servicing obligations for subsequent years. Other factors compounding unpredictability of budget support include the non-fulfilment of the government with certain conditions in the performance assessment framework, the full budgeting of the performance tranche and the absence of a common response mechanism. Furthermore, except for the EC, donors have worked primarily with annual budget support agreements with the GOSL.

To summarise, the budget support operation in Sierra Leone has been a relatively effective aid modality. In a situation of chronic budget deficits, high level of aid dependency and limited absorptive capacity, budget support has shown to play a critical role in buttressing the reform agenda while strengthening its capacities to manage public finance. Through the focus on accompanying technical assistance in the area of PFM and governance, budget support became an important instrument of capacity building. Budget support has not only mattered because of its volume in supporting the government budget, but also because of its stabilizing force on macro-economic management, reinstating trust into a long-term partnership between the GOSL and the international community, and providing an anchor for more coordinated aid programmes. Yet, more attention should have been paid to its design features, i.e. the volume, predictability and conditionality. In addition, a more appropriate complementing of general budget support with other aid modalities focusing on health system building (like sector budget support or pooled funds) at sector level could have proved to be more effective.

4.2 Multi-Donor Trust Fund in South Sudan

4.2.1 Definitions

With the advent of new and innovative aid mechanisms, there is growing interest in how a MDTF can contribute to increased aid effectiveness. MDTFs are a variant on pooled funding from allied donors with a multi year commitment, in support to multisectoral development or for a single sectoral plan. Their arrangements include legal agreements with all donors, which specify governance procedures covering the trust fund management, operational and financial reporting, and the allocation and use of the funds. MDTFs are used frequently in post-conflict environments to manage fiduciary risks. According to Leader and Colenso (2005), there are a wide variety of trust funds in use in fragile state contexts; respectively targeting post-conflict reconstruction, humanitarian response and/or security sector reform. Trust funds are usually country specific but some are regional or global involving an administrator (e.g. WB or United Nations Development Programme (UNDP)) and an oversight council.

MDTFs have gained in popularity as an aid mechanism that is seen as a means of improving coordination of donors and as an instrument of forging improved alliances and partnerships. They can also enhance harmonising of donor approaches in support of government plans; reinforcing the opportunity for nascent governments to be in the driving seat for decision making. The multi year fund is perceived to provide greater predictability and has potential to promote more efficient resource allocation. The opportunity to reduce transaction costs due to deployment of a single fund with a single set of reporting and procurement procedures is perceived as a major benefit both by post conflict governments and by donors. In order to explore the effects of introducing an MDTF, we will examine the evidence from Southern Sudan with particular attention to its impact on meeting the health service delivery objectives and concomitant system building in a context of early recovery.

4.2.2 Lessons learned

Southern Sudan health system was completely decimated, following the country's emergence from 23 years of civil war in January 2005, which was marked by the signing of a Peace Agreement. A reconstruction and development trust fund (2005- 2011) was established within the policy framework for early recovery by the Government of Southern Sudan (GoSS), in collaboration with their international development partners. A

co-financing modality was agreed with a ratio of 2:1 (GoSS: Donors). The MDTF, for which the donor partners committed a total of \$538 million, was established as the major aid modality. The health sector program as funded under the general MDTF, known as the Umbrella Health Program, received a total of \$225 million; this is currently in its second phase of implementation (2008-2011).

The objective of the health sector MDTF is to support the Ministry of Health (MoH)-GoSS to develop core health sector systems and capacities and increase the population's access to basic health services. As such, this three-year program has multiple objectives including (i) development of the health system while (ii) concurrently supporting rapid expansion of service delivery and (iii) selected high-impact preventive health interventions (World Bank, 2008).

It is now four years since the signing of the CPA and South Sudan continues to struggle with an overwhelming scale of impoverished social services, poor infrastructure and virtual absence of capacity at the county level to render essential services. Government expenditure for health is estimated at 8% since the establishment of the transition government in 2005. Health service coverage is estimated at 40%, equal to that of the decades of conflict; with NGOs providing an estimated 86% of the basic health services in the country. Complementary funding for the health sector is mainly provided by USAID bilateral fund, DFID Basic services fund, Global Fund and various private sources of funding.

Gaps in national capacities and MDTF complexity created delays

The GoSS appointed the World Bank as the administrator of the MDTF-South Sudan (SS). Adoption of WB fiscal and procurement procedures resulted in major delays in signing of contracts with consequent gaps in delivery of quick impact health interventions and the basic package of health services. A recent MDTF Oversight committee report (MDTF OSC Minutes, 2008) noted that: limited procurement capacity and lack of streamlined procedures for rapid response on procurement actions are the most binding constraints to accelerated implementation of the entire MDTF-SS portfolio. In addition, financing through 'on-budget support' under the MDTF co-financing agreement between the GoSS and the international donors assumed a minimum capacity for financial management within the Ministry of Finance (MoF) and MoH, which was not the case. Capacities have to be strengthened at all levels of the system, both central and peripheral

ministries require intensive technical assistance. This has caused major delays in delivery of health services and equally in mobilizing capacity building and infrastructure rehabilitation for the entire health sector.

However, efforts have been made to overcome the bottlenecks and simplify fiscal and procurement procedures in order to expedite the delivery of contracts and ensure services. WB has made adjustments to procedures in line with local context capacities and the second phase of MDTF Southern Sudan is expected to accelerate delivery of its objectives.

A question of aid effectiveness; multiple objectives

Evaluation reports on Southern Sudan MDTF (Fenton, 2007; Save UK, 2008), contest that the MDTF had multiple and potentially contradictory objectives; build state capacity and ownership while contracting out service delivery to private providers. Striking a balance between the shorter term health needs and the longer term system building has not yet been achieved. Although the priority to meeting the peace dividends was clearly expressed by the government, health services including high impact interventions were not delivered due to (i) the cumbersome procurement and fiscal procedures, as adopted by MDTF. (ii) capacity deficits within the key Ministries led to delays in decision making and in addressing the objectives in the Interim National health policy and strategy and (iii) decentralized planning and management delays due to weak capacities at the state levels of the MoH. (Refugees International, 2008)

Nevertheless, it is evident that the opportunity to provide multi year funding commitment by donors with co-financing by the GoSS was favourable to aligning behind the recovery plan for Southern Sudan. Harmonisation of international stakeholders continues to be a major challenge, in part attributable to more state avoiding approach of humanitarian donors and International NGOs (INGOs) who continue to respond to a vacuum in healthcare and funding for delivery of services. Meanwhile, funding predictability also came into question, as the original commitment of funds by GoSS was revised in view of fiscal constraints by the treasury. A re-alignment with the international donor community was made in 2007 in order to ensure adequate funding for sectoral priorities.

Lack of local ownership and involvement of civil society, including NGOs

The MDTF has undoubtedly met with a series of challenges during its early phase of implementation. It is frequently alleged by NGOs, that it is not the right aid instrument to

deliver basic services in transitional settings; arguably due to a myriad of constraints including structural, staffing and management issues. Fenton (2007) in a study on NGO perspectives on funding mechanisms for Southern Sudan highlights the failure to involve civil society sufficiently in the design, implementation and monitoring of the MDTF. NGOs conclude that civil society engagement was limited at the early stages; NGOs were not involved in the assessment and planning stages while proving their capacity to provide the mainstay of basic health services (86%) to the population both during and after the war. With the contracts for service delivery currently in progress, NGOs are more actively engaged as the primary contractors for basic health services and there are greater efforts to engage in coordination with the MoH and align with the umbrella health strategy.

State building at the expense of service delivery?

Reactions to the first phase of Southern Sudan MDTF have shown that there is over emphasis on its contribution to harmonization, alignment and state building with less attention to its contribution to ‘tangible goods’ for the population (Fenton, 2007). Balancing between wider state building priorities and more immediate service delivery needs has resulted in continued gaps in meeting the essential health needs of the post conflict affected population. This issue also points to the tension between phasing the priorities of state building and the delivery of more tangible peace dividends including basic services. Disappointment over failure to deliver on peace dividends post-CPA was voiced by government workers who recognize that the basic services are not reaching their communities on the scale promised. The flaw may well lie in the assumption that the MDTF has the capacity to address all of the basic service needs in Southern Sudan while at the same time promoting national government capacities and stewardship.

Indeed, in the past four years, various funding mechanisms have proliferated to respond to the immediate service delivery needs, e.g. DFID Basic service fund, UNDP early recovery fund and extension of the European Commission Humanitarian Office (ECHO) and USAID humanitarian funds for delivery of primary health care, thus revealing the importance of complementary aid instruments.

In sum, MDTFs can be a catalyst for improved coordination and creating an enabling environment for development. Southern Sudan MDTF has met with mixed results; NGOs initially viewed it as an inappropriate instrument for transitions while the joint donors and

WB as fund manager, who have invested in pooling the funds and administrative management respectively, are eager to ensure its success. Meanwhile the government recognise its potential for leveraging of funds to support the national strategy and capacity building of their institutions but were equally frustrated by the slow start up and failure to provide the long awaited peace dividends following a protracted conflict.

MDTF Southern Sudan is now in its second phase of implementation whereby efforts to simplify procurement procedures and adapt them to local context have been undertaken. It is well recognised that there are inherent tensions between the immediate service delivery objectives and that of longer term systems building; the MDTF may have overstretched its limits by endorsing multiple objectives from the outset. Finding the balance in order to overcome expensive trade offs between the short and longer term objectives continues to be an issue.

While it is acknowledged that the MDTF is not a panacea, a rethink on managing expectations regarding speed of delivery and overcoming the obstacles through accelerated financial and procurement procedures is called for. Pooled funds are still relatively new as instruments in early recovery contexts; they are likely to continue given the level of government and donor interest and potential to subscribe to improved harmonisation and alignment. Efforts to adopt a mix of aid mechanisms that allow for complementarity are critical, if the much needed services and capacities are to be delivered without extended gaps.

4.3 Humanitarian project aid in Liberia⁷

4.3.1 Definitions

Humanitarian project aid refers to non governmental organisations (often international) delivering services directly to the population. It is the most common funding mechanism during times of conflict and can be extended during the early recovery phase when there may be a lack of capacity within government to generally provide services or a lack of willingness to deliver services to some specific groups of people (e.g. based on ethnicity). However, the funding has short funding cycles and most donors have limitations on what the funding can be used for; mostly focusing on direct service delivery with limited opportunities to use it for more longer term capacity building. Finally, humanitarian

⁷ Based on Liberia Case study, by P. Vergeer and J. Hughes, Annex 5 in: *Post-conflict health sectors: the myth and reality of transitional funding gaps*, 2008, by Canavan et al.

project funding provides reduced risks for donors as it is mainly implemented by external actors, often INGOs, who are able to meet more stringent accountability procedures.

4.3.2 Lessons learned

In 2003 fighting ended in Liberia, after fourteen years. Since then, the security situation stabilised as disarmament occurred and elections were held in 2005, which were considered free and fair, and the government has since taken control of public affairs. The international community viewed Liberia at the crossroads of regional security and recognising the important progress the government made in regard to reforms. This was evidenced by international debt relief and the development of an interim PRSP. A three year strategy has been implemented since mid-2008 which continues the abolition of user fees for education and health, while the 2007 national health plan promotes a basic package of health services to be delivered. However, 75% of the functioning health facilities still rely on the assistance of NGO or Faith Based Organisations (MoHSW, 2006).

An extension of humanitarian project funding upon request of the current Minister of Health and Social Welfare occurred as major gaps were anticipated if relief NGOs withdrew their support. He highlighted at the start of 2007 that the Ministry was not yet in a position to take on this role due to limited capacity and requested project support would remain for an additional two years. Consequently, donors like ECHO extended their support for an additional two years while Irish Aid and DFID increased contributions to the health sector.

Humanitarian project funding ensured the continuation of basic services

Health service delivery continued after the peace agreement, with support provided by NGO's and Faith Based Organisations (FBO's). However, as relief aid mainly aims to reduce the mortality rate, the focus has been on immediate life saving interventions, comparable to humanitarian services during the war. Similarly, the same geographic areas are supported as before; although coverage of health services to ensure access is not yet fully known. A basic package of health has been developed by the Ministry of Health and Social Welfare (MoHSW), to be implemented by all health facilities.

Exit of humanitarian project funding can leave gaps in service delivery if not well planned

With 75% of the health facilities supported by NGOs, their withdrawal would be expected to leave a gap in support to basic health services. Early 2008, many NGO's highlighted that it was not yet known how the ending of relief funding in 2009 will affect the support they provide to the health facilities. A long term strategy, developed by the MoHSW, donors and NGO's, is recommended to ensure the delivery of services in the medium to long term. A phased approach to handover responsibility for supporting clinics (e.g. paying staff, supervision, supplying medicines) to the Ministry can be considered. Contracting to NGO's is currently being piloted and may create a modality of continued support to the service delivery, although sustainability is to be considered. Attention should therefore be given to the longer term role played by local NGO's and FBO's in the health sector.

Relief project funding does not usually contribute to health system building

Ensuring the continuation of service delivery through extending the humanitarian aid has been important but it does not necessarily contribute to (re)building the health system five years after the ending of the conflict. For example, training of health staff has often been limited to short term (refresher) courses due to donor restrictions and the short term funding cycles. In addition, relief agencies recognise that they may not necessarily have the capacity or skills required to contribute to health system building. Many essential functions of a health system (such as medical supplies, monitoring of health information and financial management) have not been functioning and thus need to be revitalised. Liberia's decentralisation policy will furthermore place additional demands on the capacity and management skills at decentralised level.

Project funding through humanitarian agencies reduces risks but does not enhance state ownership

Accountability by NGOs to donors rather than the government of the post-conflict state does not enhance state ownership and control. Equally, assuming a stewardship role requires capacity within the MoHSW to take such a lead and coordinate the aid provided. Consequently, humanitarian agencies have continued their parallel coordination structure in Liberia. DFID and Irish Aid for example, have recognised the limitation to the state ownership and have introduced a pooled fund for the health sector with increasing stewardship by the MoHSW. Conversely, some donors adopt a project funding approach,

whereby funds can only be provided to non-state actors and not to or through government. Nevertheless, these donors are also exploring ways to enhance state ownership and further exploration of these innovations in Liberia is recommended.

In sum, the continuation of humanitarian project aid in Liberia has been essential to ensure the continued delivery of health services. It has been an appropriate response to the limited capacity as expressed by the Minister. However, humanitarian project aid in its current design was found to be lacking in health system building due to short and successive project cycles and limited capacity building components. The health sector in the early recovery phase requires a dual approach of health service delivery as well as health system building, while the humanitarian project funding primarily focuses on the former. Humanitarian project aid furthermore extends the reliance on external actors while government ownership and control is limited, which prolongs the humanitarian modality and delays the development modality. Although recent efforts of contracting health services under MoHSW stewardship may improve this, but this is part of the pooled funding approach which is more development in aim.

Given that the willingness of the MoHSW seems to be high and the main issue is that of limited capacity, it brings to the fore the need for complementary aid mechanisms (such as TA) that work more with and through government or flexibility in existing instruments (humanitarian project aid) to ensure required health system building occurs during the early recovery phase.

4.4 Technical Assistance in Timor-Leste

4.4.1 Definitions

TA is the provision of advice and/or skills in the form of specialist personnel to the partner government. It includes training, scholarships and grants for research and associated costs. Partner governments use TA (also often referred to as technical cooperation) to access advisory skills and services, to pilot and implement new policy approaches and for capacity development (OECD DAC, 2008).

TA has been an important element of development aid approaches, both as stand-alone or in combination with other aid modalities, to build wider human and institutional capacities and systems and to make the financial assistance of development partners more effective. According to *figure 1* it would fit into the objectives set of ‘systems building’ /

‘state engagement’ with the ultimate aim to strengthen government capacity to deliver efficient and effective public services to the poor. The principal challenge for TA is how to move beyond temporarily filling capacity gaps towards sustainably building capacity of partner governments over the medium- to long-term.

In fragile states the need for TA is especially daunting, and addressing the associated challenge to ensure capacity development is particularly grave as national systems have often been decimated, needs for services are immediate and the main pillars of the state (executive, legislative, judiciary) are only partly in place. In addition, Brinkerhoff (2007) highlights that the approach to capacity building in fragile settings, such as early recovery needs to consider the following elements:

- *Longer time required to achieve an increase in capacity* and the mismatch between the timeframe within which donors can commit funding, human and organizational resources and the timeframe needed to achieve capacity development targets is usually larger in fragile states.
- *Higher degree of difficulty and complexity associated with early recovery contexts.* Capacity development becomes more difficult because the operating environment tends to be hyper-politicised. In societies that have been fragmented by deteriorating or conflict conditions, capacity development that fails to yield quick results or that deliver benefits to one societal group and not another risk being perceived as ineffective and unfair.
- *Greater magnitude of the change* that the donor intervention seeks to achieve, which requires both more time to accomplish and is increasingly complex to achieve. Rather than big-bang approaches, capacity building with the help of TA needs to be an incremental reform process.

4.4.2 Lessons learned

Timor-Leste is the world’s youngest nation and has experienced a turbulent history. It was occupied by Indonesia from 1974 to 1999, which has been marked by extreme violence. Following the fall of President Suharto in 1998, Timorese voted in a referendum for their independence - a decision which was followed by Indonesian violence led by armed militia. Political instability has continued during post-independence and has been marked by a series of outbreaks of violence since.

Timor-Leste's public sector is characterised by significant human and institutional capacity gaps, including inadequate skills among civil servants, institutional fragmentation of key functions of government combined with a highly politicised civil service, weak management and leadership, and inadequate information systems. This is the immediate result of decades of Indonesian occupation but also the approach chosen to capacity building by the international donor community. During the Indonesian occupation, the majority of technical and middle and senior management levels in the local administration were held by Indonesians whereas Timorese only held lower-level positions. Upon withdrawal of the Indonesian Administration in 1999, 7000 Indonesian civil servants left the country leaving a dearth of experienced or skilled personnel for all positions and all sectors of government. Subsequently, during the United Nations Transitional Administration in East Timor and continuing after Timor-Leste independence in May 2002, most of the administrative and technical positions were filled by United Nations (UN) staff and other expatriates.

Since 2003 experience in Timor-Leste with capacity development in general, and TA more specifically were evaluated extensively (Irish Aid, 2008; UN Security Council, 2006; UNDP, 2007; World Bank, 2007; Norad/Scanteam, 2007; AusAid, 2007) and highlighted a number of concerns. An exploration of the health sector (Vergeer, 2008) reveals most concerns also apply to TA provided to the health sector, where the following lessons can be learnt:

TA has focused on complex systems rather than a “back to basics approach”

Many within the MoH argue that attention is needed to assist in the development of simple tools, in a language that everyone understands and with input from those involved in the implementation. Capacity building efforts instead have emphasised the introduction of sophisticated systems, rather than getting the basics right first, which has only broadened the capacity gap further. A case in point is the development of an advanced computerised health information system while basic support systems such as computers and training on its use are not yet in place, especially at decentralised level. Programme design has often been overly optimistic and complex, which in the light of extreme low capacity is unlikely to match individual and institutional absorption capacity. Instead an incremental approach to capacity building is required which can be adapted and evolve, based on the context and growing capacity of the MoH.

Limited national ownership for capacity building approaches exist

Many within the Ministry stress the need for ownership when it comes to TA: all the way from identification to implementation, reporting and monitoring. The disposal of TA has often not been based on adequate baseline assessment of skills and knowledge, as well as of ministerial functions, mandate and systems. This has undermined the appropriate fit with existing needs and conditions and put pressure on the implementation of the day-to-day activities.

The MoH has been proactive in trying to better coordinate TA through a Forum which aims to share "...information, insights and experiences on how better assist MoH line managers (TA counterparts) to perform their duties." (MoH Timor-Leste, 2008, p.3) Some TA's recommend that such discussions should be held, preferably prior to the development of the Terms of Reference in order to promote greater ownership of the MoH over the capacity building efforts within their ministry.

Capacity building efforts have been fragmented and focused on substitution or individual capacity building in the short-term rather than institution building in the long-term

Following the departure of many experienced Indonesian health staff, TA to the health sector has focussed primarily on substituting/filling existing capacity gaps rather than ensuring sustainable transfer of skills. The main rationale of the "TA model" has been to support national counterparts for a limited duration, often on an ad-hoc basis. The focus was primarily on individual capacity building (advice, training) and less so on the institutional framework (systems and processes) and changes in behaviour and incentives. This has been undermined by the lack of adequately educated and skilled counterparts, the still evolving role of government, limited experience of many staff in public administration and decision making, and a lack of wider performance based incentives in light of slow civil service reforms.

Various donors increasingly recognise the need for enhanced support to the educational level of local counterparts. As a result, first attempts are undertaken to review the value of peer reviews, twinning with institutions in other countries, and scholarship programmes in the context of building foundations for skill transfer from international TA to national civil servants. In addition, a change in the working culture and attitude of national staff supported by TA is also required towards taking ownership and responsibility for the

tasks at hand and pro-actively applying themselves their new skills to day-to-day operations.

The TA support has furthermore been provided through a diverse group of donors, NGO's and UN agencies. This is mentioned as often having complicated or confused issues around implementation, as one health staff noted: "different advisers say different things and/or different advisers working on different elements of a particular issue which then do not fit well together." Many within the Ministry advocate for a more coherent approach which will strengthen the overall functions of the health system rather than its separate aspects. So far, most TA support has been short-term in nature while the MoH has frequently been unable to provide counterparts to international TA specialists. Individual/departmental capacity building plans which include agreements on how skills will be transferred, what processes and instruments will be developed and what will be achieved in which time frame, are not yet in place.

Overall, Timor-Leste has made important progress in building basic capacity of the state. Undoubtedly the large size of TA has contributed to ensuring basic service delivery continued, often through various degrees of substitution. Experience over the past years has shown though that much of this effort has been limited in coverage, projectised, fragmented, donor-driven and unpredictable. The approach to capacity building has been more ad hoc and short-term in nature, often building the capacity of individuals, rather than (re)building the functions of the health system in the longer term. Within the MoH we furthermore noted that the technical assistance tends to be reliant on various donors supporting advisors for different aspects of aid coordination, health systems strengthening and vertical programs. Consequently, little knowledge and skills have been sustainably transferred to Timorese and wider health institutional and organizational capacity change has been slow.

5. Discussion: Gaps and synergies of aid mechanisms in early recovery

The previous chapter focused on exploring to what extent different aid mechanisms serve early recovery efforts in the four case study countries (Sierra Leone, Southern Sudan, Liberia and Timor-Leste) with analysis of GBS, MDTF, extended humanitarian project funding and technical assistance respectively. The case studies revealed important considerations to limit gaps in addressing the needs and enhance synergies of the aid mechanisms as relevant to the health sector during the early recovery phase:

Balance the service delivery and health systems building objectives appropriately

The health sector is characterised by a multiplicity of objectives in the early recovery setting, as it requires both capacity for service delivery and health system building. While realising the context specificity of these findings, we can derive from the case studies that the aid mechanisms reviewed have mostly served one objective successfully rather than multiple, i.e. service delivery, systems building, state partnering or avoiding approach during the early recovery phase. This presents a dilemma for donors and for governments in terms of mandating multiple objectives, which cannot be readily achieved through adoption of a single aid mechanism. The use of budget support in Sierra Leone and the MDTF in South Sudan reveal their limitations in ensuring continued health service delivery and demonstrated in both contexts the need for associated aid mechanisms to boost more immediate health service objectives. Conversely, the extension of humanitarian project aid in Liberia revealed its constraints in contributing to health system building. *A coordinated approach is recommended to ensure appropriate mixing and sequencing of aid modalities during the early recovery phase to attain continuity of services coupled with capacity building to strengthen the health systems. In addition, more comparative studies are needed into the effects of aid mechanisms serving multiple purposes in different contexts and whether lessons can be transferred across contexts in relation to successes and challenges encountered.*

Capacity building support needs to recognise the complexity and vacuum of capacity during early recovery

There are multiple forms of capacity building support in operation during early recovery, but invariably insufficient for the purpose of building the core capacities of new central and peripheral systems in a country where even the most rudimentary systems are decimated. Most post conflict countries witness a major vacuum in human resource

capacities at all levels of the state. This has direct consequences for the effectiveness of those aid modalities (e.g. GBS, MDTFs) which are conditioned upon a certain minimum level of government capacity, as witnessed in Sierra Leone or Southern Sudan. The time needed to reach optimal technical and management capacities, and the required time to achieve this magnitude of change is much greater in early recovery settings than in traditional development contexts.

TA is used in many early recovery settings and is an important adjunct to budget support and other aid instruments. Nevertheless, many countries are still devoid of adequate TA to national administrations in transition, while extended gaps exist in the post conflict phase before donors commit longer term funding for technical assistance. In addition, the timing of TA provision can be lengthy, whereby some donors seem to have more complex mobilisation and procurement procedures than others. However, TA should not wait until the peace treaty is signed.

TA to governments is required at the pre-planning phase to assist in conceptualization of recovery strategies and advise on the choice of aid modalities. As opposed to big-bang approaches, we advocate an incremental approach to capacity building. This was evident in Timor-Leste where TA tended to be more ad hoc and fragmented due to reliance on diverse donor provision to vertical programs or duplication of support to specific areas of health systems strengthening. Instead a coordinated approach is necessary which ensures the complete spectrum of health system building is catered for, next to relevant capacity building support to the delivery of health services.

Capacity development should be an endogenous process, strongly led from within the country and with donors playing a supporting role. Political leadership and the prevailing governance systems are critical factors in creating opportunities and setting limits for capacity development. The focal point of capacity development efforts should be shifting from focusing narrowly on organizational and public management approaches towards a broader perspective that incorporates both the institutional rules of the game within which public organizations operate and political dynamics. *A coherent, longer term plan for capacity building needs to be developed with involvement and ownership by the government to ensure the appropriateness and sustainability of the support provided.*

State partnership is influenced by donor policies and the choice of aid mechanism

The different case studies highlighted the need for strong partnership with governments during the critical transition phase. Increased state ownership leads to development efforts which have greater potential to foster local ownership and legitimise the national government. The different case studies explored in this paper revealed that donor policies and behaviour were seen to play a major role; with some donors specifically following a state-avoidance policy while others promote a state partnership approach. An example of the latter was seen in Sierra Leone which experienced a strong alliance with the major donors in the immediate early recovery phase. The choice of aid mechanisms was also seen to be guided by in-country factors, such as government's commitment to reform or the capacity of state structures to deliver services as witnessed in Liberia. *More flexible application of the aid mechanisms even during the relief phase is likely to accelerate health system strengthening and enhance state ownership during early recovery, although it is recognised that state partnership does not merely depend on the choice of the aid mechanism. Piloting and further research into the feasibility and effectiveness of such early health system strengthening activities is warranted.*

Management arrangements of aid instruments are key to aid effectiveness

The management arrangements and design features of aid instruments can strongly influence their effectiveness. This seems to be even more important in early recovery settings, where government capacity tends to be weaker and more fragile, and economic variables and hence financing needs can change quickly. Equally, donor driven conditionality does not allow sufficient ownership and flexibility for governments to implement reforms; the likely consequences are that funding will be late and insufficient to effectively support the reform process. *Adapting aid instruments to the context and capacity of each setting is therefore recommended.*

In addition, predictability is essential to allow for more long-term planning of the health sector recovery as also advocated at the Accra conference in 2008. The choice of aid mechanisms can influence aid predictability and also determine the speed of mobilising resources to the point of delivery. The coordinated use of aid instruments can ensure that they become mutually reinforcing and bridge possible funding delays. Hence, *better harmonisation and coordination of the use and complementarity of different aid instruments is called for to deal with delays and overcome gaps that are a result of how aid instruments are used.*

6. Conclusion: Rethinking the use of aid mechanisms in health sector early recovery.

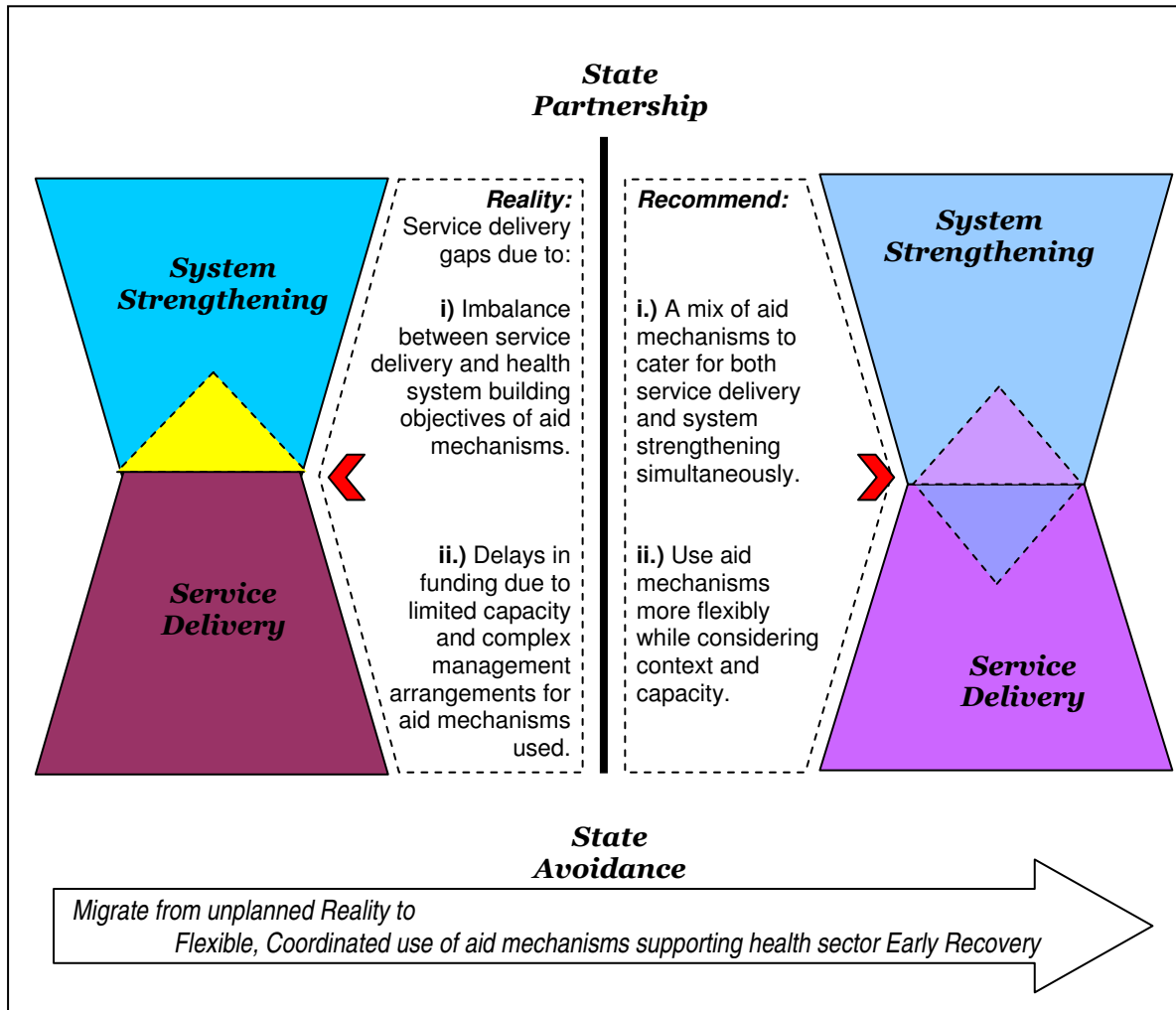
This paper has explored the use of specific aid mechanisms during different early recovery contexts. While the case studies show that there are multiple determinants which influence the outcome and effects of aid mechanisms, some specific findings can be shared in relation to the contribution of aid mechanisms to the early recovery of the health sector.

During early recovery, the health sector requires a continuation of health service delivery while simultaneously building the health system. The case studies reveal that the objectives of aid mechanisms as related to relief and development often follow different parameters; relief aid is more state avoiding while development has a state partnership/ownership approach with relevant capacity building of the MoH. These often contradictory objectives were found to be difficult to attain through the use of a single aid mechanism. Modalities that foster state partnership and system building, like budget support or MDTF, can work in fragile states if they carefully take into account the particular country circumstances and the relatively lower capacity. However, the complexity of some of the aid mechanisms used and the limitations to available capacity to implement them saw a (potential) disruption to the service delivery in several countries.

Establishment of interim or substitute aid mechanisms to respond to anticipated or real gaps usually occurred 'ad hoc' and unplanned. For that reason, the former practice of progressively advancing from aid mechanisms which focus primarily on health service delivery and are state avoidance in nature, to those which are partnering with the state to strengthen the health system requires rethinking. Instead a paradigm shift is required, as illustrated in *Figure 2*, which allows for an integrated mix of modalities used to balance the multiplicity of objectives (state, non-state, systems building, service delivery) in early recovery settings. Consideration is to be given to the particular context and capacity to adapt the specific aid mechanisms appropriately and to attain a suitable mix and sequencing of the aid mechanisms. Comparative studies of the flexible use of aid instruments to serve the multiplicity of objectives is furthermore warranted. In addition, accommodating earlier implementation of activities to strengthen the health system may facilitate earlier recovery of the health system. Piloting of the feasibility of health system

strengthening activities at an earlier stage and evaluating different implementation methods on its effectiveness is recommended.

Figure 2: Paradigm shift to improve aid effectiveness during early recovery



Better coordination of donor agencies at country level is recommended to determine choice of aid instruments and their complementarity, in order to ensure that health service coverage for vulnerable populations is maintained while simultaneously (re)building the health system. There is also scope for donors at country level to discuss and agree who is best positioned to support which activity, and how they can complement each other through the use of different aid mechanisms to cover the multiplicity of objectives apparent in the health sector during the early recovery phase.

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