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HEALTH SERVICE DELIVERY IN EARLY RECOVERY FRAGILE STATES LESSONS FROM AFGHANISTAN, CAMBODIA, MOZAMBIQUE, AND TIMOR LESTE

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HEALTH SERVICE DELIVERY IN EARLY RECOVERY FRAGILE STATES

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MOZAMBIQUE, AND TIMOR LESTE

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Executive Summary

This case study explores some key themes in the emerging literature on service delivery in fragile states in light of the health sector experience in four early recovery countries—Afghanistan, Cambodia, Mozambique, and Timor Leste. The analysis considers the various impacts of foreign assistance on state stewardship of the health sector and the programming implications. The investigation starts with state effectiveness and legitimacy.

Findings point to the importance of and structural impediments to donor harmonization in re-establishing health services in a post-conflict context. United Nations (UN) coordination in all four countries was constrained by state avoidance strategies, a spike in aid flows that were out of sync with emerging government capacity, and—in Cambodia and Mozambique—an emphasis on highly visible but largely unsustainable infrastructure projects that were limited by the absence of a planning framework. Harmonization and alignment of aid systems and accountability requirements—current pillars of fragile states programming—were enabled through joint frameworks, common approaches, and trust funds that offered direct budget support that strengthened government systems, accountability, and a common policy framework in Afghanistan and Timor Leste.

Overall, accountability requirements by the various donors, coupled with their concerns that their efforts receive clear attribution, and the establishment of project-based fragmented assistance to the non-governmental organization (NGO) sector in all countries in the relief, transition, and developmental phases served to draw capacity out of the civil service, setting up a two-track system that has significantly undermined central and, more particularly, provincial capacity and authority to regulate service delivery. Promising initiatives for improve donor harmonization include sector planning, budget support, trust funds, pooled funding, and alignment—recognized but so far unfulfilled in all cases.

Capacity-building efforts have been limited by a restricted focus on skill building rather than power sharing and particularly a lack of control over resources. Concerns with government fiscal systems and weak technical capacity have justified state avoidance in Cambodia, Mozambique, and Timor Leste. Foreign assistance has disabled capacity building through a continued tendency towards project-based aid, stand-alone project management units, vertical programming, and technical assistance that “acts” rather than mentors. The impact of these trends may undermine leadership, ownership, and, at times, the fragile social contract between governments and civil society. Government passivity in the face of multiple, shifting, and unpredictable donor requirements and aid flows is evident, and a resistance remains to engaging with private sector service delivery agencies—which have demonstrated greater service delivery efficiencies.

Attention to wages and benefits for health workers and asymmetries with NGO wages surfaced as critical determinants of state capacity and the ability of provincial health offices to plan and manage.

The ability of external assistance to directly impact on legitimacy is more limited than its potential impact on effectiveness through policy, capacity, and systems strengthening. Donor expectations of NGOs as civil society agents may be diluted by their role as service delivery contractors.

Promising approaches to support state stewardship include: 1) contracting with NGOs—in Afghanistan and Cambodia; 2) equity funds—in Cambodia; 3) civil service performance-based reform—in Afghanistan; 4) sectoral plans—under discussion in all countries; and 5) budget support.

Acronyms

ADB	Asian Development Bank
AREU	Afghanistan Research & Development Unit
BASICS	Basic Support for Institutionalizing Child Support
BPHS	Basic Package of Health Services
CDIE	Center for Development, Information, & Evaluation
CHW	Community Health Workers
DAC	Development Assistance Committee
DfID	Department for International Development, UK
DHS	Department of Health Services (Timor Leste)
EC	European Community
EU	European Union
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoM	Government of Mozambique
HMIS	Health Management Information System
HSRDP	Health Sector Rehabilitation & Development Project (Timor Leste)
ICORC	International Center On Response to Catastrophes
INGO	International Non-Governmental Organization
MoF	Ministry of Finance
MoH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization

ODI	Overseas Development Institute
OECD	Organisation for Economic Co-Operation & Development
ONUMOZ	United Nations Organization for Mozambique
QIP	Quick Impact Project
PIU	Project Implementation Unit
PRR	Priority Reform and Restructuring Program (Afghanistan)
PRSP	Poverty Reduction Strategy Papers
SACB	Somalia Aid Coordination Body
SWAp	Sector Wide Approach
TA	Technical Assistance
TBA	Traditional Birth Attendant
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNTAC	United Nations Transitional Authority in Cambodia
USAID	United States Agency for International Development
WHO	World Health Organization

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1 Introduction

The past decade has been marked by a global concern with the number of countries that are unwilling or unable to adequately ensure their people's security and development needs. These so-called fragile states are distinguished from sustainable development states by broad governance and public management weaknesses based on cracking, broken, or still undeveloped relationships between and among the institutions of government, the private sector, and citizens. These structural weaknesses contribute to a downward spiral of poverty, insecurity, conflict, and failure. They manifest as political, ethnic, or economic instability, centralized decisionmaking, and widespread corruption, which makes the effective absorption of external aid problematic.

Fragile states are typically beset with woefully inadequate service delivery. Not surprisingly, fragile states are among the poorest—one-third of all people living on less than \$1 a day live in fragile states. Nearly half of under-five deaths every year occur in these countries. Moreover, in this post 9/11 era, fragile states are also perceived to put global peace, stability, and public health at disproportionate risk (Collier 2002; Goodhand and Atkinson 2001).

This case study is part of a larger global effort to understand and better program for service delivery in the context of fragile states¹ with a view toward improving overall state governance and the public health. Fragile states are not homogeneous, nor is there unanimous consensus about typology and criteria. There is general agreement that programming in states with low capacity (a *sine qua non* for fragility) and high willingness is easier than in states that are reticent, recalcitrant, or chronically unstable. This paper examines perhaps the most promising cluster—early recovery fragile states—defined by the Development Assistance Committee (DAC) as “countries where some efforts are being made to improve performance, but where performance is patchy. These countries might be post-conflict or countries where conflict is not the primary driver. Often, there is no strong leadership championing reform within government, and capacity to implement reforms is generally weak.”

This paper explores some of the key themes from the emerging literature on service delivery in fragile states in light of the experience in the health sector in four early recovery countries—Afghanistan, Cambodia, Mozambique, and Timor Leste. These are all post-conflict countries (though low-grade conflict continues in Afghanistan). Afghanistan and Cambodia would have easily fit the “arrested development” cluster at a previous point in time. Some would argue that Mozambique might be headed in that direction as well. All offer enough of a retrospective look at state building (or rebuilding) efforts and a reservoir of literature and key informants to allow insights and comparisons about the evolution of the health sector and lessons from foreign aid. The paper is based on a desk review of available published and grey literature and interviews with experts familiar with the contexts. Informants are not noted by name in the text to respect confidentiality.

¹ This is the first of a quartet of cases, commissioned by USAID to the BASICS project. The cases adopt the Organisation for Economic Co-Operation & Development (OECD)/DAC typology of fragile states: deteriorating governance, post-conflict transition, arrested development and early recovery.

2 Frame of reference

Good governance, including the state's ability to competently manage its own resources and provide security and equitable development for its citizens, is at the heart of the fragile states paradigm. The state's integrity and resilience is a reflection of its legitimacy and effectiveness² (United States Agency for International Development [USAID] 2005).

Legitimacy is defined as the extent to which the population believes that the state authority is worthy of its support. By more competently managing its resources and providing security and equitable development for its citizens, a fragile state can gain a measure of legitimacy. One indicator of legitimacy is the state's ability to provide social services to the population.

Effectiveness is defined as the extent to which the state is able to deliver essential security and other services to the population. The quality, coverage, cost, and consistency of these services offers a measure of the state's effectiveness as the steward of these services (Ghani et al. 2005).

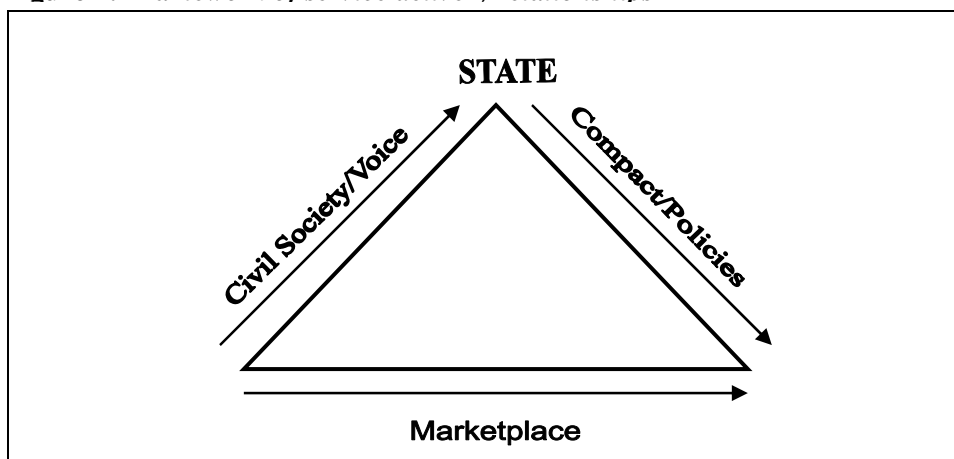
The *World Development Report 2004* offers a helpful conceptual framework for understanding three accountability relationships that enable legitimacy and effectiveness in the health sector (see *Figure 1*):

1. Between citizens (consumers) and the state: the long route of accountability through civil society and other democratic institutions such as the media, elections, and advocacy, which give citizens a say in policies—as a measure of legitimacy.
2. Between the state and providers: the long route of accountability through regulatory mechanisms such as standards, salaries and structures—as a measure of effectiveness.
3. Between consumers (citizens) and providers: the short direct route of accountability through the marketplace (Loevinsohn n.d.)

Legitimacy and effectiveness interface in important ways, the dimensions of which may help to define context-appropriate interventions. Improving service delivery effectiveness, which would include more emphasis on decentralization and citizen participation, as well as more robust mechanisms for transparency and multiple layers of accountability, may serve to encourage state reform and contribute to legitimizing the state in the eyes of the population. Aid investments in service delivery effectiveness may also be advanced to legitimize donor commitment in the eyes of the state—an entry point for broader, more sovereignty-sensitive interventions.

² Legitimacy and effectiveness are USAID's indicators of resilience. Some argue that these matrices reflect the political orientation of the U.S. government's fragile states initiative. DfID (Department for International Development, UK), as well as other European donors and the World Bank, include commitment to pro-poor or equity concerns as an essential variable.

Figure 1: Framework of service delivery relationships



But external assistance is, necessarily, circumscribed in terms of what it can do to strengthen any of these accountability relationships. On balance, it has greater potency in strengthening (and potentially undermining) effectiveness than legitimacy, which is less receptive to external and programmatic solutions. Creating durable democratic institutions in an early recovery context may take a generation or more and rely on dynamics in the political, cultural, and social environment that may be beyond what development assistance (putting aside other diplomatic or strategic options) can achieve. While donor investments in strengthening civil society's ability to articulate and advance a health-related agenda has intrinsic merit, in an early recovery or post-conflict context, such programs may find only a limited popular or political constituency in the face of immediate security, economic, or employment imperatives. The ability of foreign assistance to improve the service delivery sector's *effectiveness*, on the other hand—through policy reform, systems strengthening, investments in infrastructure, inputs, human resource development, and so on,—has already been demonstrated in early recovery and other development contexts, as discussed in this paper.

Health sector programming inside the fragile states paradigm requires not only a wider-angle lens, but also the necessity of grappling with the sometimes messy and almost always ambiguous political realities that characterize fragile states. This frame of reference is different in important ways from the public health frame of reference in which medical solutions to most problems are well known and scientifically validated. The intersection between this governance paradigm and public health solutions defines the parameters of the new paradigm—or the search for it.

The countries. The fall of the Taliban in Afghanistan (2001), the ousting of the Khmer Rouge and withdrawal of Vietnamese forces in Cambodia (1989), the end of the decades long RENAMO insurgency in Mozambique (1992), and independence in Timor Leste (1999) put each of the countries considered here in the global spotlight. Each had its own critical health needs as a result of conflict and the rapid movements of large numbers of people, poor hygiene, poor nutrition, and poverty. The health systems in all four countries were devastated by conflict with infrastructure destroyed, systems in disarray, and trained personnel having fled the country or to safer urban areas. State functions and the integrity of the civil service emerged tattered but resilient in Mozambique, and a cadre of adept civil servants remained after the ousting of the Taliban in Afghanistan (Pavignani and Colombo 2001; Afghanistan Research & Development Unit [AREU] April 2004). In Cambodia the legacy of Pol Pot had more or less decimated government capacity, including the health work force (World Bank 2004). In newly independent

Timor Leste, only 25 doctors remained once the Indonesian health managers and doctors fled (Tulloch et al. 2003).

The analysis. The paper will consider how foreign assistance has impacted on the long routes of accountability in these early recovery states. How did foreign assistance boost (or indeed undermine) state stewardship of the health sector (section 3)? How has foreign assistance strengthened (or not) the democratic institutions that enable civil society to effectively interact with the state in the health sector (section 4)?³ What lessons can be drawn, and what promising practices have emerged that might be useful for other early recovery contexts?

³ The policy compact and civil society voice impact in important ways on consumer service choices. Consideration of these impacts on this “short route of accountability” via the marketplace will be embedded in the discussion of the longer routes that follows.

3 Strengthening effectiveness of the health system: the long route of accountability

This section looks at how donors related to one another and how donors related to the state in providing assistance to the health sector in the four early recovery contexts. Common themes in donor-state relationships are considered in terms of:

1. Harmonization of donor inputs
 - Early planning efforts
 - The coordination role of the UN post-conflict
 - A shared vision and resources to support it
 - Leadership
2. The structure of foreign assistance to the health sector
 - Supporting the state
 - Avoiding the state
 - Structural issues on the aid side
 - Cultural issues on the state side
 - Human resources for health
 - Rebuilding infrastructure

3.1 Supporting state stewardship: harmonization among donors

The discussion of aid support to state effectiveness begins with what is, intuitively, the most straightforward for aid agencies: cooperation with one another. In its broadest sense, so-called *harmonization* implies coherence among the approaches, policies, and systems of aid agencies with one another and the national government (OECD 2004). Importantly, it includes an alignment of fiscal and administrative systems with government systems. The current literature advances harmonization and alignment as critical for redressing aid inefficiencies, leveraging greater recipient accountability, and reducing the likelihood of uneven geographic coverage and orphan sectors or sub sectors (Overseas Development Institute [ODI] 2005; OECD 2004).

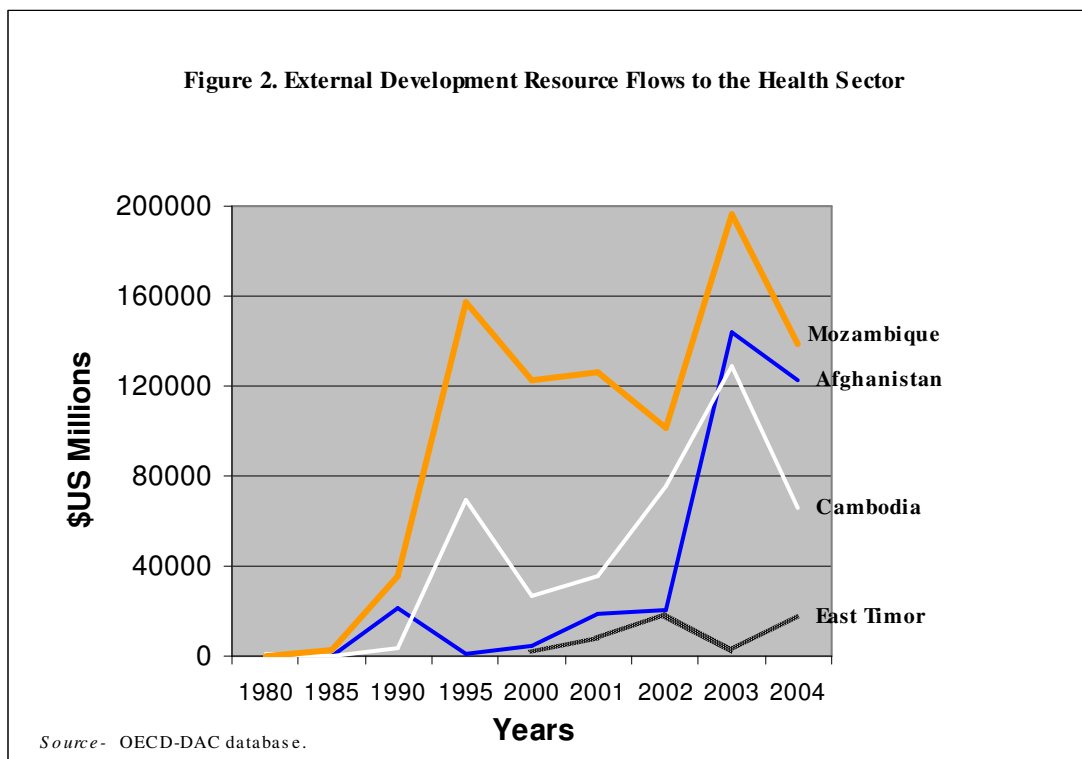
A reality check reveals an aid landscape characterized by a multiplicity of uncoordinated, project-based aid streams. Growing calls for donor harmonization in recent international fora reflect a broadening awareness of the negative impacts that these disjunctions have had on service delivery systems, state stewardship, and even sovereignty. The history of foreign assistance in the early recovery periods of the four countries provides ample evidence in this regard.

The last two decades have witnessed an upsurge in internal or regional conflict in poor countries. Reflecting broader trends, the World Bank's portfolio for post-conflict countries increased 800 percent between 1980 and 1997 (Lanjouw et al 1999). USAID reports tripling its Official Development Assistance on humanitarian assistance between 1990-98 (USAID 2001). Indeed, it has been suggested that post-conflict response represented a major growth industry⁴ (Lanjouw et al 1999).

⁴ Per capita aid in the first five years following conflict varies enormously—ranging between \$30-67 per capita for Cambodia, Mozambique, and Rwanda, compared with \$209 to Timor Leste and \$247 for Bosnia and Herzegovina and—shedding some light on the political dimension of resource allocations (Rohland and Cliffe 2002, citing data from the World Bank Statistical Information and Analysis).

Remarkably, there is a striking lack of historical data on consolidated aid flows to the countries in question and the health sector more specifically. OECD has just begun to collect this type of aggregate data, which is still limited to bilateral and multilateral aid flows. Comprehensive data does not exist; to date, no international databases that include the significant flows from NGOs, foundations, and individual donor sources exist. This finding is consistent with the structural and strategic impediments to collaboration among donors and, in some cases, with the state as discussed below. In addition, and perhaps more disturbing from this retrospective perch, is the possibility that recipient countries would have been unable to ascertain a clear consolidated picture of aid flows at any point in time, with significant resources flowing “off budget” for humanitarian and development purposes. Further aggravating this situation are significant discrepancies between pledged and paid resources that appear to characterize all contexts (though verifiable data was difficult to find even for recent post- conflict countries such as Afghanistan and Timor Leste). The state’s inability to predict external resource flows has been identified as an impediment to effective planning and management of resources, both important determinants of fragility, as discussed below.

With these caveats in mind, figure 2⁵ provides an indicative indication of aid flows to the health sector in the four countries under discussion.



⁵ The data in this figure are taken from the OECD DAC Creditor Reporting System (CRS) that include aid flows from DAC donors and multilateral donors including the World Bank, regional development banks, the International Fund for Agricultural Development, and a number of UN agencies. The figures also include both grants and loans, but only refer to aid provided for development assistance. The figures are a compilation of two sector categories: health and population. The DAC defines “Health Totals” as aid that covers assistance to hospitals, clinics, other medical and dental services, public health administration and medical insurance programs. Health Totals can also be viewed as subcategories: Health General and Basics Health. “Population Programmes” are defined as aid that covers all activities in the field of reproductive health, family planning, and research into population problems.

As figure 2 illustrates, the countries under study benefited and were beset by a post-conflict spike in external humanitarian assistance and the number of external actors on the scene. Although progress cannot be discounted, multiple demands and advice from assorted external health sector stakeholders left fragile ministries gasping for breath or retreating into passivity in ways that are now recognized as undermining broader governance objectives. This period left its imprint on the process that followed and rebuilding efforts in health sector recovery.

More recent emphasis on global funding in the health sector and the DAC's initiative to aggregate such data since 2003, reflect an early tangible step in the direction of the global harmonization agenda. While harmonization remains a work in progress in all of the countries, certain elements help unpack some of harmonization predictors in an early recovery context. They include:

1. Leadership: from government or a donor agency
2. Donor willingness to plan and manage collaboratively
3. Donor willingness to pool resources.

Early planning efforts

Geo-political considerations were important determinants for post-conflict planning in all four countries. Ideological concerns with the socialist-leaning government of Mozambique (GOM) hampered direct partnership with the state in the early post-conflict period. This shifted somewhat as Mozambique moved towards the West. Disappointed with failing states in other parts of Africa, donors turned to Mozambique, which has continued to enjoy their largesse. In Cambodia, in the 18 months following the expulsion of the Khmer Rouge, humanitarian aid from the West flowed, subsiding after the UN declared an end to the emergency. Eastern Bloc and Vietnamese assistance prioritized provider training and re-establishing the hospital sector until the Vietnamese withdrawal in 1989 (Hill 2002). Following the Comprehensive Settlement of the Cambodia Conflict (1991) with the UN Transitional Authority for Cambodia (UNTAC) in place, the recovery effort was marked by a surge in external assistance,⁶ including concomitant flows to the health sector. The health sector configuration, ambiguities in the political situation, and a decimated civil service conspired against the development of a coherent health sector vision; significant fragmentation in service delivery resulted, which persists to the present.

To this day, the donor communities in both Cambodia and Mozambique continue in an almost schizophrenic struggle with coordination—with strong recent statements and some steps towards greater harmonization and alignment, while at the same time inclined to continue to channel diminishing resources around the state. This trend is also relevant for other so-called “arrested development” fragile states.⁷

By contrast, in post-9/11 Afghanistan and newly independent Timor Leste, quickly legitimizing the new governments was a shared urgent priority around which all donors could rally. Health sector planning began before the conflicts were over in both Mozambique and Timor Leste. This helped to galvanize a focus on post-conflict reconstruction. Health sector planners had important links to political leadership, a factor considered important in post-conflict recovery (Rohland and Cliffe 2002; Pavignani and Colombo 2001).

⁶ Foreign assistance jumped from US\$17 million in 1989 to US\$317 million by 1993.

⁷ The DAC defines arrested development fragile states as states that fail to use their authority for pro-poor priorities. The state's ability to exert its will might be very weak (anarchic) or very strong (authoritarian). Donors are typically unwilling to deal with the state directly (OECD 2005).

The coordination role of the UN post-conflict

In all four countries, a UN authority was empowered with a mandate for relief coordination, as well as everything from reintegration, demobilization, and (in the case of Cambodia and Timor Leste) maintaining all state functions leading up to an election. Even in the “high willingness” contexts under consideration here, the humanitarian bureaucracy operating in the fast-paced, politically complex environment found it difficult to achieve coordination mandates, challenging coherence in support of state-building initiatives (Ghani et al 2005).

UNTAC, and its Mozambican counterpart, the United Nations Operation in Mozambique (ONUMOZ), proved unable to manage the onset of donors rushing to claim a space in the highly politicized environments in each country. In Cambodia, as aid skyrocketed, concerns about political factionalism challenged UNTAC coordination. “Major donors, in particular the United States and to a lesser extent the European Donors, including the European Commission, sought to maximize their room for manoeuvre by working outside the coordination regime they themselves had worked to establish” (Lanjouw et al. 1999). With continuing concerns about government legitimacy and low-grade conflict that lasted until the late 1990s, most donors choose to support service delivery through non-state⁸ providers.

The humanitarian phase in Mozambique followed a similar (although slightly less politically charged) trajectory, with competition and rivalries among UN and bilateral agencies and the Banks resulting in missed opportunities in particular for supporting state legitimacy (Marshall 1998). The multiple mandates of the transitional authority—ONUMOZ—responsible for political reconciliation, demobilization, resettlement, and reintegration as well as humanitarian efforts, combined with longstanding internecine rivalries within the UN family, rendered the powerful United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) (under the ONUMOZ) a threat. “Many agencies considered coordination of humanitarian assistance as unnecessary, an obstacle to their programme, or even an invasion of their turf” (Pavignani and Colombo 2001).

A shared vision and resources to support it

The willingness of donors to pool attribution and accountability, and share the costs of harmonization in the post-conflict period and beyond also relied on leadership and broad agreement on a workable framework or approach.

Rebuilding the health sector in both Afghanistan and Timor Leste benefited from a relatively well-coordinated aid response based on an agreed-upon approach to service delivery and Ministry of Health (MoH)⁹ leadership. Strategies also benefited from lessons from other post-conflict states and perhaps the reality that both countries were more or less starting from scratch in terms of a new health sector vision.

Harmonization efforts in the early reconstruction period in Timor Leste were supported by a commonly agreed upon framework for action. The flexible, practical planning tool included achievable budget-based targets. Harmonization was addressed through six-monthly review meetings including regular joint donor missions, and importantly, secure funding to the state through the Trust Fund for Timor Leste (ODI 2004; Tulloch et al. 2003). In Afghanistan,

⁸ Non-state actors can include NGOs, international NGOs (INGOs) and for-profit firms. In this paper, they will be referred to interchangeably as NGOs, non-state providers, and civil society organizations.

⁹ “MoH” is used generically in this paper to describe central state health authorities in all the case countries, except in Timor Leste where a distinction is made between the Interim Health Authority and its successor, the Department of Health Services.

recognizing the comparative advantage of NGOs to respond to the enormous need, key stakeholders coalesced around a common approach to performance-based contracting. While resourcing and management mechanisms vary somewhat, the common approach has formed the platform for rationalized national coverage and greater (albeit not complete) alignment of key systems with the state among the contracting out schemes supported by the World Bank, European Community (EC), and USAID.

Harmonization efforts in Cambodia and Mozambique have not fared as well. By 2001, \$425 million in external aid to Cambodia was significantly outstripping government revenues. The new government's inability to make solid progress in establishing overall legitimacy and effectiveness in the health sector was due in no small measure to the multiplicity of implementing and financing structures and differing (sometimes contradictory) policy advice from multiple directions. A number of coordinating bodies attempted to bring some order into the health sector in Cambodia, but none, except the International Center On Response to Catastrophes (ICORC), are addressing issues of resource allocation or coordinated support to building state capacity (HLSP 2003; Lanjouw et al. 1999; World Bank 2005).

The Swiss Development Cooperation led the first attempts to coordinate development assistance in Mozambique in 1990. Subsequent efforts at pooled funding, sectoral planning, and better coordination have been attempted with promising albeit uneven results, as discussed below. Many of the major actors health sector, including the European Union (EU), USAID, and World Vision, have resisted harmonization efforts and gone their own way (Pavignani and Colombo 2001). According to a 2000 report that the EC published, weak donor coordination and disagreements among donors about MoH capacity and commitment was reflected in a disproportionate amount of aid (\$100 million from some 27 donors by 2001) still flowing around the state to the health sector (Brown 2000; Montes et al. 2000; Pavignani et al. 2002). EU funding between 1992 and 1996 alone—representing half of the resources being channeled through NGOs in the health sector—supported 57 projects implemented by 33 NGOs, a UN agency, and the MoH (Colombo 1997, cited in Pavignani and Colombo 2001).

Even with a shared vision and strong leadership in the early recovery phase in Timor Leste, however, harmonization and cooperation tended to fray at the edges around divergent agendas, mechanisms, and donor government reporting requirements. Tulloch et al. (2003) report numerous examples of bureaucratic bottlenecks to budgeting, planning, and implementation encountered because of the multiplicity of requirements from participating donors. In the reconstruction period, there were reportedly six discrete funding mechanisms, making the synchronization of infrastructure rehabilitation and civil service recruitment problematic (Rohland and Cliffe 2002).

These obstacles to efficiency are echoed throughout the literature and represent just the tip of the iceberg in terms of underlying challenges to achieving harmonization.

Leadership

Leadership was an important variable in early recovery initiatives. In Afghanistan, a strenuous debate among stakeholders marked the lead-up to the decision to move ahead with a national scheme for performance-based contracting to service delivery NGOs. Observers credit strong leadership from the World Bank and the MoH with coalescence around the approach as well as the forward momentum in rolling it out (Strong et al. 2005). Harmonization also benefited from the fact that many of the current leaders in government, and donor and other key agencies have longstanding, personal, and professional relationships with the country and one another.

Leadership from within the Interim Health Authority and subsequently, the Department of Health Services, is similarly credited with some of the risky decisions that have shaped the Timor Leste

health sector (Tulloch et al. 2003). The reconstruction framework provided a roadmap and a process that enabled government leadership to emerge over time (Rohland and Cliffe 2002). Similarly, technical cooperation in Mozambique made progress in the early recovery period under dynamic senior leadership in the MoH. This changed abruptly in 1995 with a new administration that was more hospital-oriented, more indecisive, and less inclined to manage or coordinate external assistance.

While difficult to program for, recognizing and supporting leadership are important in the early framing stage of beginning recovery efforts.

The situation today. The Millennium Development Goals and the Rome (2003) agreement on harmonization have raised the volume and some momentum in favor of greater donor harmonization. In December 2004, on the heels of the Rome Declaration, a joint government-donor Declaration on Harmonization and Alignment was promulgated in Cambodia (World Bank 2005). As development stakeholders recognized the ill-effects that rapid growth and fragmentation of aid were having in Mozambique, the Kaya Kwanga Code of Conduct was put forward, calling for common procedures, consistent pay rates, transparency, and a movement towards budget support to reduce perverse incentives that were drawing capacity out of the government. In addition to NGO stakeholders, USAID, the World Bank, the UN, and the EC signed the code (Pfeiffer 2003). Indications are that without sanctions that can be implemented related to the commitments implied in these agreements, they have had little impact in practice.

On a broader scale, donor harmonization has gained some traction in Mozambique with nearly a dozen donors providing joint budget support that funds approximately half of the GoM's budget. The so-called G-11 group (which now includes 14 donors¹⁰) has used this mechanism as a productive platform for joint planning and policy dialogue. Nonetheless, most of the participating donors continue to provide a mix of assistance, with greater funding for health still flowing into the NGO and private sector (USAID 2004). In Cambodia, a disproportionate percentage of health sector aid continues to be disbursed off-budget (HLSP 2003).

Summary and further questions. Validated models and guidelines for harmonization are emerging, as described in the following section. But significant structural and political impediments remain. Easterly (2002) observes that even cooperation—a first step towards harmonization—is in fact illusive because by its very nature the “cartel” of aid agencies that share a common purpose are also competitors for the same political turf. Not surprisingly, larger donors are cited as more frequent outliers (Birdsall et al 2005; Christiansen et al 2005; Loevinsohn n.d; OECD 2005; Waldman 2005; Walt et al. 1999). Coordination adds transaction costs on the donor side and may be perceived as less valuable than attributable outcomes (OECD 2005). Harmonization, which goes beyond information sharing and requires individual donors to cede attribution and a measure of control over models, methods, and strategies in favor of national control and aligned, coherent, state-supporting strategies and systems, remains an unmet ideal in early recovery contexts.

Technical solutions cannot make much progress without political leadership from the state or, secondarily, a strong donor with the confidence of the state and other donors. Indeed, several observers note that bureaucracies and bureaucrats can resist coordination and harmonization because enforced competition or chaos offers more opportunities for personal leveraging and less accountability demands. When donors speak forcefully together, sensitivities about sovereignty may arise. In Timor Leste, the intensive biannual reviews under the planning

¹⁰ Belgium, Denmark, the EC, Ireland, Finland, France, Germany, Italy, Netherlands, Norway, Portugal, Sweden, Switzerland, and the UK.

framework were resisted after some time, based on sovereignty sensitivities from the state (Buse 1999; USAID June 2005). We will return to this issue below.

3.2 Promising approaches for early recovery harmonization

The previous discussion alluded to a number of current modalities for achieving harmonization in the health sector. The list includes (Ghani 2005; Pavignani 2005)¹¹:

- Joint planning/planning missions
- Transitional and long-term development planning frameworks
- Shared targets and indicators
- Harmonized or joint funding mechanisms (e.g., trust funds)
- Reciprocal accountability mechanisms (among donors or with governments)
- “Compacts” defining clear complimentary programming roles
- A lead or mediating agency
- A role for government monitoring (against national frameworks)
- Codes of conduct
- Memorandum of understanding (MoU).

To be productive in an early recovery context, these modalities must be: 1) inclusive of most major donors in the sector; 2) budget-based; 3) realistic in terms of resources and capacity; and, 4) flexible enough to be adjusted as situations change.

Three approaches from the literature review are considered here:

Sector plans

The development of a comprehensive health sector vision and integrated plan has been advanced as a method of maximizing harmonization, consolidating alignment, and establishing collective accountabilities. A sector wide approach (SWAp) can be anything from a “whole of government” approach to a framework for mapping and organizing efforts, like the transitional plan used in Timor Leste.

Pavignani (n.d.) in his *Swamped in a SWAp* offers a mixed report card on SWAp’s to date. Unsurprisingly, the effort to bring coherence to aid flows and strategies that a SWAp requires also surfaces different and sometimes discordant agendas among donors and between donors and governments, and highlights the costs of coordination. Donors may see the SWAp as diluting their agendas and attribution; governments may see it as centralizing their power and raising the ante on expectations. Bureaucratic resistance on both sides to plan activities in advance may also be hampered by the unpredictability of resource flows (Pavgnani et al. 2002). Finally, because of the enormous effort involved in putting a SWAp together, there is a risk of it feeling like a “make or break exercise which leaves little but frustration in place if it fails”

¹¹ Other examples from arrested development contexts include: the World Health Organization (WHO) points to Transitional Results Matrix in Liberia as best practice model for harmonization (WHO conversation September 2005), but a USAID health, population, and nutrition (HPN) officer admits little cooperation takes place (conversation 2005). The Somalia Aid Coordination Body gives development partners a mechanism for sharing information and joint response; it has performed best in the health sector based on strong leadership. The Somalia Aid Coordination Body (SACB) enabled the Somali transitional government a focal point for dialogue (Pavignani 2005).

(Pavignani n.d.). Easterly (2002) goes further, questioning whether the whole endeavor of a complex, multi-stakeholder planning exercise is a possible diversion from the real structural issues with aid. Citing the example of Cambodia, where 10 international consultants are preparing the PRSP (Poverty Reduction Strategy Paper—a multi-sectoral plan) with World Bank guidance, he questions whether it really achieves local ownership

Some version of a SWAp is under discussion in each of the case countries, but the most recent literature indicates that it is considered premature in Timor Leste, untenable in Cambodia because of concerns about government frailties, and challenged in Mozambique because of donor discrepancies (Montes and Wolfe 2000; Pavignani and Colombo 2001).

Trust funds

Trust funds have been used in Afghanistan¹² and Timor Leste to underwrite government budgets in the post-conflict and transitional periods.¹³ Trust funds offer donors overhead efficiencies (since only one agency manages the fund), harmonization opportunities, and accountability assurances. They offer governments reliable funding streams to cover government salaries and other costs, over which they may have more leverage than project-based aid (Byrd 2001). In Afghanistan and Timor Leste, government/donor dialogue, planning frameworks linked to resource allocation, and built-in conditionalities linked to disbursements have been reported as important positive contributions to accountabilities and efficiencies in rebuilding the health sector (Leader and Colenso 2005; Rohland and Cliffe 2002). Specifically, they provide a framework for a broader discussion between donors and government about fiscal and development policy (Schiavo-Campo 2003). Positive impacts on state stewardship could be inferred from the literature, although they were not specifically documented.

While trust funds, by definition, harmonize assistance provided by participating donors, they also dilute attribution, which may limit their attractiveness to some. It is interesting to note that USAID, which typically finds it challenging to participate in pooled funding mechanisms,¹⁴ contributed about half of its 1999 congressional earmarks for Timor Leste to the Trust Fund for Timor Leste. To do this, it considered the funding a grant to the managing agency, the World Bank. A follow-up review found that Bank management minimized corruption, built government capacity, and fostered government priorities (USAID June 2005).

Pooled funding

For many years in Mozambique, a group of European donors have been contributing to a number of joint funding mechanisms designed to support provincial recurrent costs as well as drug and technical assistance (TA) procurement. The funds have many of the trust fund

¹² The Afghanistan Reconstruction Trust Fund was established in 2001, when the World Bank re-entered Afghanistan after a hiatus of nine years. Seeded with debt relief funds and contributions from 24 other donors, the fund has managed over \$852 million to date and is the main instrument for meeting the country's recurrent budget. Some of the funding was earmarked for specific sectors and some for general budget support. In 2005, \$59.6 million was disbursed to the health sector (World Bank 2005).

¹³ Leader and Colenso (2005) suggest that this is a more appropriate mechanism for "pro-poor" fragile states, since it provides direct government support.

¹⁴ USAID provides a number of types of non-project assistance, including food aid, balance of payment support, commodity import programs, sector assistance, and debt relief. In 2003, USAID commissioned a study of General Budget Support in Mozambique. At this time it was providing 85 percent of its resources through project-based aid implemented through NGOs and 15 percent for sector assistance (USAID 2004).

advantages, described above. The MoH, with Swiss Development Corporation administrative support, manages the funds. Interestingly, there have been other funds for other services that failed to thrive, largely because of the absence of a dynamic manager.

While modest (\$5 million/year), the three pooled funding mechanisms are reportedly viewed very positively by civil servants as a sign of trust and have served to lower transaction costs for the participating agencies (Brown 2000; van Diesen 1999). In a special arrangement, funds go directly to the MoH rather than through the Ministry of Finance (MoF) according to mutually agreed-upon administrative policies (van Diesen 1999). Launched initially by a handful of donors, the number of donors joining the scheme continues to grow. Still today, the pooled support for TA and drugs only covers one-third of the requirements for drugs and less for TA (in 1998), a situation which falls short of achieving national coherence and the ability of government to provide national oversight for these inputs (Brown 2000).

3.3 Supporting state stewardship: foreign assistance and the state

An effective health delivery system relies, ultimately, on the state's ability to regulate and rationalize the quality and reliability of inputs and services. External assistance can support stewardship through strategies that empower and strengthen leaders and state delivery or state regulated systems. This section considers lessons in terms of six dimensions of the aid response to the challenge:

1. Supporting the state
2. Avoiding the state
3. Structural issues on the aid side
4. Cultural issues on the state side
5. Human resources for health
6. Rebuilding infrastructure

Promising approaches from the four countries are presented at the end of this section.

Supporting the state

The health systems in the early recovery countries considered here continue to be characterized by uneven coverage and quality. Consumers still depend disproportionately on the unregulated private sector for services (Bhushan et al. 2002).

All four countries depend on foreign assistance to meet more than half of their operating costs. In Afghanistan it is as high as 90 percent. Aid responses in these countries to weak capacity fall broadly into three categories: 1) build capacity; 2) help the state to organize private providers; and, more recently, 3) align aid systems with state systems to help bolster fiscal, logistics, human resource, and other systems vital for supporting service delivery.

Building capacity. Enhancing clinical skills is arguably the most straightforward of the array of capacity-building requirements in an early recovery context. Weaknesses in management and leadership skills and the ability to create, manage, and enforce accountable systems and policies are directly linked to governance. Traditional aid responses to capacity weakness are well known: provision of short- or long-term technical assistance, planning exercises, training, revamping systems, and—in the most capacity deficit situations—hiring expatriates to fill gaps in expertise. All these approaches were applied in the early recovery case countries. Pavignani et al. (2002) highlights a number of deficiencies in current capacity-building efforts: 1) a focus on individual skill building in dysfunctional environments; 2) reinventing the wheel each time; 3) piecemeal interventions—lack of a strategy; 4) using blueprints; 5) lack of understanding of

incentives and disincentives in existing systems and contexts. These are validated in the cases and argue for approaches that build on what works, but adapt skillfully to local capacity and political realities.

The cases also support the argument of Goodhand and Atkinson (2001) for the need to reframe capacity building in terms of power relations as well as to develop new habits and skills. Citing an example from Liberia they report: “Capacity building . . . has remained at the level of skill transfer, rather than any fundamental change in power relations. Liberian agencies still lack policy influence in relation to international organizations.” This is fairly universally true in terms of direct support to the state as well. To take a well-worn development metaphor: there is little value in teaching a person to fish if the would-be fisherperson has no resources to buy rod, tackle, or bait, or transport the fish to market.

The slow process of mentoring or broad systems change may be harder to achieve in the face of imperatives to demonstrate project results. In their study of Cambodia, HLSP (2003) suggest that “Capacity building is often seen as a derived or secondary objective linked to meeting project objectives.” Indeed, technical assistance (or personnel charges) represents a stunning 45 percent of project spending, and 21 percent of total domestic and externally financed investment spending for health in Cambodia (HLSP 2003). In Mozambique—which many consider today to be a post-fragile state-- health sector technical skills tripled in the 1990s, but capacity remains weak (Pavignani and Colombo 2001).

Successful capacity building may rely less on skills transfer than on context-relevant problem-solving skills. Strong et al. (2005) offer an example in Afghanistan of particularly effective capacity from a Department for International Development (DfID) advisor who, in addition to fulfilling his technical remit, helped the MoH to develop a strategy to manage a growing number of donors and even how to chair a meeting. Technical assistance is more effective when there is a mentoring, rather than a “doing for” approach.

NGOs have been an important training ground for future leaders in the government health sector in Afghanistan and Timor Leste (Rohland and Cliffe 2002; Strong et al. 2005).

A rush to training may be similarly ill-conceived outside of a larger framework for trainees. An observer recalls a major management training effort for district public health officers in Timor Leste. Undertaken in the early rebuilding days, the training was conducted without the benefit of a national human resource development plan, job descriptions, supervision guidelines, or follow-up support. Not surprisingly, there was little evidence of impact a year later.

Many informants for this case expressed concerns about the sheer number of external advisors in the health landscape in the four countries—a pattern that is repeated widely. In Timor Leste, with a small handful of senior managers at the central level, there are 13 advisors in the MoH alone. In Papua New Guinea, there are reportedly 19 expatriate advisors in the MoH and 15 more in the provinces. In such circumstances, it is easy to imagine how local managers may be inclined to share or even relinquish decision-making and miss important the opportunities for learning (Leader et al. 2005). The Government of Ethiopia reportedly recently sent 80 percent of their expatriate advisors home.

At the same time, technical assistance initiatives can themselves suck capacity out of the system that it seeks to strengthen. This happens when the best talent is hired into donor agencies, NGOs, and private firms, which are then tasked with capacity-building responsibility. In such circumstances, it is easy to see how fragile systems might find it difficult to absorb capacity-building inputs.

Capacity building without resources stands out as a strategy option for risk-averse donors, designed to signal commitment, but falling short of the investments need to realize genuine

governance goals. Capacity-building efforts are more likely to succeed when managers and leaders have control over resources and decision-making.

Contracting with NGOs. Government contracting of NGOs has been used in three of the four countries under study—all places where NGOs were already delivering the lion's share of health services. Contracting with NGOs has significant appeal in an early recovery context in which service delivery can help to establish state legitimacy. It has significant appeal as a state-managed organizing mechanism to prevent or restructure a fragmented, unruly, or unregulated private sector. When contract management and payments originate in the MoH, there is significant potential to shift accountability from donors and NGOs to the state and achieve greater alignment of systems and policies in a disparate health system,.

In Timor Leste, the Department of Health Services (DHS) contracted with NGOs to mobilize post-conflict service delivery and support early district-level planning. NGOs that had been operational before and during the humanitarian period were contracted to continue services on a short-term basis and provide support to the development of district health plans. MoUs were abbreviated, and none were renewed (Tulloch et al. 2003). This marked a rapid exodus of NGOs (some of which were not really clinically oriented in any case) after the first year (Rohland and Cliffe 2002). This bold move on the part of the new DHS was part of an overall plan to downsize the health system, consistent with a long-term view of anticipated resource availability.¹⁵ It also allowed the DHS to retain control of the rebuilding task at hand (Ministry of Health 2002).

In retrospect, in an observer's view, the rapid downsizing may have been precipitous, leaving fragile administrative and clinical capacity at both central and district levels. A few NGOs have remained to provide specialized services, and a number of donors are still active in the health sector (Rohland and Cliffe 2002). There was not enough information in the literature to draw final conclusions about the government-NGO relationship, which has been more ad hoc in the aftermath. Chronic management and service delivery weaknesses and fragmentation at central and provincial levels are widely acknowledged, however. This raises questions about whether another service delivery contracting phase (or, at minimum, capacity building) to NGOs might have produced different health systems outcomes.

Operations research on contracting out, underway in Cambodia since 1998, offers solid data for the approach and informed its formulation in Afghanistan. In Cambodia, districts where NGOs were contracted to deliver services performed better than districts where the MoH was contracted under analogous terms (and provided management support). NGO sites demonstrated significant gains in terms of coverage, cost, equity, and time lost to illness. A \$4 per capita annual investment in services produced a \$35 per capita annual *drop* in out-of-pocket health-related expenditures for the poorer half of the target clientele (Bhushan et al. 2002). Today, NGOs deliver services on contract to 11 of Cambodia's 71 districts.

In post-Taliban Afghanistan, NGOs delivered 80 percent of health services. The system was urban focused, highly focused on medical treatment, and hospital centered. NGOs offered the only viable critical mass of clinical and management capacity. Contracting out was quickly deemed the approach of choice. In this case, NGOs or clusters of NGOs were contracted to provide coverage to entire provinces. Three major donors—USAID, the World Bank, and the European Commission—are underwriting NGO contracting except in a few provinces, which are

¹⁵ There were 406 health facilities pre-1999 to 158 post-1999; the number of doctors employed by the public health system dropped from 135 to 25 in the same period.

covered directly by the MOH¹⁶ (Strong et al. 2005). The early national adaptation of a government-led health delivery strategy for contracting of NGOs to deliver a basic package of health services (BPHS) has served to avoid some of the pitfalls of other early recovery contexts by organizing the externally supported private sector under state leadership.

Early challenges and issues arising in the rollout of the contracting out approach in Afghanistan may inform the adaptation of this approach in other early recovery contexts:

1. **Cost recovery** is still being debated within the MoH, based on divergent interpretations of the constitutionality of charging for services.
2. **BPHS staffing** was an issue, given the uneven availability of staff and skills nationwide.
3. **Aligning systems**—for instance, drug procurement, which is still project-based.¹⁷
4. **Integrating vertical systems** into the BPHS approach.
5. **The for-profit sector's role**—an issue that is under discussion.
6. **Decentralization** and a stewardship role for the provinces (Sondorp 2004).

Although it is too early in the Afghan experience to measure the national strategy's epidemiological or institutional benefits, key informants are informally unanimous that the greater harmonization and alignment of aid to date has impacted positively on efficiencies and effectiveness. Early results indicate that coverage has improved significantly, and alignment with government systems has benefited. The development of state regulatory functions is inevitably slow and appears more problematic at the provincial level (see below) (Sondorp 2004; Strong et al. 2005). USAID plans to transition management of NGO contracts from a U.S. contractor to the MoH in 2006—an important real and symbolic step in support of state stewardship.

• **Aligning state systems and policies.** Alignment behind national systems and policies—budgeting cycles, procurement, contracting and civil service regulations, internal boundaries and so on—may be one of the most important and most challenging implications of the harmonization agenda (OECD 2005). Alignment shifts ownership and accountability for aid outcomes from external aid agencies and their partners to governments—thus “future proofing” aid delivery for enhanced state stewardship (ODI 2004).

In Afghanistan, based on a common approach, progress toward systems alignment was achieved with the national health management information system (HMIS), the civil service performance and review process, and a national policy on human resources, consistent with the nationally sanctioned BPHS. An estimated two-thirds of NGOs and government facilities report through the HMIS.

Measuring change. Key studies proved invaluable in creating a common baseline of information for the multiplicity of actors in the early recovery stage in all the countries. Rohland and Cliffe (2002) suggest that in the immediate post-conflict period, it is more important to assess the state of infrastructure and human resources than the health situation, which is typically already known. A rapid assessment of facilities, undertaken by the Interim Health Authority in Timor Leste, for instance, provided legitimacy to a national plan (Tulloch et al. 2003). In

¹⁶ Since July 2001, 44 contracts have been let to 32 NGOs that cover 70 percent of districts and 59 percent of the population.

¹⁷ USAID's managing agent procures in bulk for its NGO contractors, while World Bank and EC contractors reportedly fend for themselves on the open market—raising concerns about cost and quality.

Afghanistan, however, where little was known about health status, the early study of maternal mortality shocked everyone and pushed the issue to the top of the government's agenda (Strong et al. 2005). In the chaotic and rapidly changing post-conflict period, there is an immediate need for information for planning. This argues in favor of quick, less rigorous and certainly less costly studies than might be appropriate two or five years out.

The accountability locus drives the measurement of results. Project-based aid tends to be inward looking, relying on epidemiological indicators to measure outcomes. Governance and even capacity indicators remain illusive, even in programs such as the major health initiative in Afghanistan, for instance, in which government stewardship is an assumed (but not measured) byproduct of the scheme (see Connell et al. 2004, for instance).

Measuring progress in a governance-driven paradigm requires information about systems resilience, administrative capacity, accountability, and customer satisfaction. Indicators that help governments understand how improvements in health status or health systems may impact on legitimacy (such as, to what extent do populations measure their governments against services delivered?) may improve political and policy-related accountability. A further need is to measure the values associated with financial and non-financial incentives for retaining human resources in the health sector, a point returned to below.

Avoiding the state

Based on the DAC definition, in early recovery fragile states, donors face capacity obstacles to state-supporting strategies, but political or strategic concerns do not hamper collaboration. Emergency assistance almost, by definition, avoids working with the state. Emergency assistance structures and mechanisms often remain into the post-conflict or chronic conflict periods when humanitarian needs persist.

The legacy of these state-avoidance strategies, particularly after a prolonged conflict, has embedded a parallel structure in the service-delivery landscape. A retrospective look at the EU's rehabilitation program in Mozambique acknowledges the ". . . lack of 'exit strategies' to ensure financial and institutional sustainability after departure of the NGOs, and little engagement with local government structures" (APT 1998, cited in Montes and Wolfe 2000). In Cambodia, a disproportionate share of the resources (and thereby decision-making) remained outside of the state purview, "deacaptiat[ing] the already weak public health service" (Lanjouw et al. 1999).

Chronic concerns with government fiscal systems, accountability, and weak technical capacity have justified continued state-avoidance strategies in Cambodia, Mozambique, and Timor Leste in donor agencies. All the countries under study experienced a dramatic growth in the number of non-state actors entering the health sector in the transitional and development periods. In Cambodia, NGOs working in the health sector exploded from 23 international NGOs and no local NGOs in 1988 to 164 INGOs and 160 NGOs operating in a "powerful but largely unrationalized sector" by 1995. In Mozambique, by 1999, EU and EU member states were supporting 67 projects in the health sector alone, with the combined annual budget of the EU-funded NGOs active in Zambezia Province amounting to several times that of the provincial government (van Diesen 1999).

In the mid-1980s, at the height of Mozambique's internal violence, almost all foreign aid supporting the health sector was channeled through the National Health System. With the bureaucracy still functioning, Mozambique was in a position to play a leadership role in post-conflict rehabilitation yet

. . . aid agencies and NGOs were keen to emphasize the seriousness of the situation and the need to act quickly and resolutely without paying too much attention to (and often deliberately ignoring) issues such as governance, administrative mandates and institutional

development. The government of Mozambique was tenacious in governing the country as far as it was allowed by rebels, aid agencies, and financiers (often pursuing in different directions). (Pavignani and Colombo 2001)

State-avoidance assistance to the health sector tends to focus on achieving health outcomes in a limited geographic or a specific type of vertical intervention. Project-based aid is often framed as a pilot activity to provide a reason for the restricted focus. But from a national governance viewpoint, localized or pilot activities commonly offer limited hope of sustainability or the opportunity to affect national change because of unrealistic cost structures (Loevinsohn n.d; Macrae 1997; Meagher 2005; van Diesen 1999).

Even policy advice has managed to avoid engagement with the state.

The weakness of public policy in these countries, together with the current preference of official aid organizations for policy based lending, means that the locus of health policy-making is increasingly internationalized—with decisions regarding major elements of the content of health policy in recipient countries frequently being made in Washington, Copenhagen and London rather than in national capitals. (Lanjouw et al. 1999)

The impact of these trends on the state may be devastating, undermining leadership, ownership and the sometimes-fragile social contract between governments and civil society (AREU April 2004; Lanjouw et al. 1999; Pfeiffer 2003). In more recent post-conflict countries such as Southern Sudan and the Democratic Republic of Congo, donors have sought more intentionally to re-engage with nascent governments. Service delivery support is seen as part of the legitimizing “peace dividend” in this regard. This trend bears watching in terms of impacts on stability and state resilience.

Provincial capacity. Disparities in resources have precipitated a brain drain from the public sector to INGOs and NGOs, which offer better salaries and opportunities, shifting the locus of control and the accountability focus—with project-based islands of excellence reportable to Washington, Brussels, or London. The impact in terms of provincial capacity and morale can be significant. The following quote from Mozambique describes a familiar situation from low-capacity environments, echoed in all four of the countries:

In most situations, NGOs had budgets higher than the local government and controlled much of the transport and communication assets. This abundance of resources placed the NGOs in a privileged position: in some cases, NGOs actively tried to take over government functions, in other instances government officials, overwhelmed by NGO initiative and capacity, simply relinquished their responsibilities. It can be concluded that if NGOs have played an important role in relief, some have also contributed, together with donors, to the weakening of indigenous capacity. In many instances the state was simply replaced, or forced to play a merely symbolic role, whereas priorities were defined and decisions taken by donors and acted upon by NGOs. Despite suffering the resource shortage, which made them unable to play their institutional role, most government officials nonetheless painstakingly revindicated it. They deeply resented the expanded space occupied by NGOs, and their unruly behavior, without recognizing their contribution to service delivery. Relationships remain strained and ambiguous to this day. (Pavignani and Colombo 2001)

The power imbalances that this scenario implies lead inevitably to tensions and skewed accountabilities.

Even in Afghanistan, where national leadership defines the NGO role, an analogous situation emerged at provincial level (AREU March 2004; Strong et al. 2005). The Mid-Term Evaluation of the USAID-funded REACH program (Connell et al. 2004) notes, “The Team is struck by the similarity of structure and purpose between the REACH offices and their Provincial Health Office counterparts. Both are creating a similar staffing structure and there is an opportunity to avoid duplication of effort by at least co-locating the two offices where possible.” Local health offices have little in the way of capacity, and resources flow directly to NGOs from Kabul. At the same time, since NGO salaries are higher and more reliable than government salaries, facilities where staff are only receiving government salaries were found to be largely non-functional. It is not surprising that local health departments find it difficult to exert their own authority in this situation.¹⁸

Returning to Mozambique for a moment, Pfeiffer (2003) describes the familiar “aid specific patronage system,” in which NGO managers—driven by perverse incentives to establish turf, increase financial “burn rates,” and achieve project cycle results—used per diem, trainings, salary top-offs, and other perks to buy participation and agreements from local officials and service providers. Inevitably, this trend (an informal marketplace among competing implementing agencies) served to empty health offices and clinics of regular staff who were constantly at paid trainings or study tours. Importantly for this discussion, it also served to undercut local government legitimacy and diverted accountability and alliances from central government to non-state actors.

Perspectives. The so-called “two track” dilemma described here has obvious implications for both dimensions of the long route of accountability. Neither NGOs nor external aid agencies can replace the state. State-avoidance strategies in early recovery contexts of “high willingness” are at best unsustainable; at worst, they undermine already-fragile effectiveness or even legitimacy. Despite government shortfalls in resources for the health sector, bilateral donors have been reluctant or sporadic in their willingness to provide direct support to underwrite recurrent costs for state services or management functions. Earmarks and other funding restrictions as well as concerns about creating dependencies are cited as major obstacles. Efforts to support broad public financial management are recognized as critical to greater government stewardship in the health sector (Flint 2004; World Bank 2005). Broad restructuring of aid flows and the relationships with non-state providers (that will continue to play an important role in service delivery into the foreseeable future) is called for. Options are listed below.

Structural issues on the aid side

Aid format and structure is ultimately a balancing act between the expressed priorities of the recipient country, the needs as perceived by donor agencies, and a complex set of strategic, accountability, and resource availability factors on the giving end. Much has already been said about some of the structural obstacles to harmonization, alignment, and the impacts on the recipient fragile states. This section reviews some of the other related structural issues that have had particular impact on the health sector in the case countries.

Timing. The generous influx of resources following a crisis is a consistent pattern, following strategic imperatives, media attention, international commitments to cementing the peace,

¹⁸ “For instance, the Herat Director of Public Health told of how his Department’s instructions for an immunization drive were overruled by the immunization initiative organized by NGOs; in this case doctors took their direction from the NGOs and not the government.” “In the case of the Afghan Red Crescent Society, the amounts paid to all staff were 50 percent more than their government salaries. The use of top-ups is generating some concern regarding reporting lines. Many staff feel responsible to the donors rather than to the Government.” Case Study: Herat Province, AREU et al., 2004.

humanitarian response, or a combination of these factors. In early recovery contexts, as the cases show, this spike in resources is often out of sync with absorptive capacity, and indeed may have some detrimental impacts. On Timor Leste:

Paradoxically, the availability of quite considerable financial resources in the first two years of reconstruction may not have been entirely positive. Funding in excess of absorptive capacity and pressure to spend can lead to approaches that will ultimately be unsustainable. (Tulloch et al. 2003)

Early funding might realize greater efficiencies three to five years down the road. This would allow for a more incremental spending horizon including time for dialogue and planning among Sectoral and political leadership and donors. Assured funding over a longer period of time would allow for the incremental establishment of state systems and capacitating staff than can manage them. Interest-bearing trust funds could be explored.

Vertical programming. Vertical or disease-specific programs are usually regarded as results oriented, based on high-performing cadres and visible measurable impacts. This has made them more appealing to donors than the less tangible, longer timeframe requirements of systems-wide strengthening. There is little evidence that successful vertical programming “rubs off” on broader systemic financial and management weaknesses, however, and there is growing consensus that systems approach is the most appropriate to achieving the Millennium Development Goals (HLF 2004, not to mention health sector resilience).

Vertical programs are often used in transition rehabilitation efforts for quick, broad, manageable coverage. Once established, programs may be difficult to dismantle. Donors may resist mainstreaming vertical programs for fear of diluting measurable results (Macrae 1997; Pavignani 2005). In Afghanistan, for instance, National Immunization Days for polio and sometimes measles persist alongside the integrated BPHS program. One informant reports: “The challenge is to achieve and maintain high immunization coverage levels using the routine program without having to rely too much on expensive and disruptive National Immunization Days.”

Project management units. Like vertical programs, the establishment of project implementation units (PIUs) in a ministry setting has been advanced to encourage state ownership, while cordoning off accountability for specific programmed resources. In the health sector, this is often, but not always, to fund a vertical program. In Cambodia, this type of project-based approach to vertical programming has reportedly led to distortions that are disruptive and ultimately unsustainable (HLSP 2003). A recent EC report about Mozambique rings a cautionary note:

...donors (including the EC) have contributed to weakening public administration by using semi-autonomous project management units and by recruiting government officials to work in their own projects, through the use of salary top-ups as incentives and through consultancies. (Montes and Wolfe 2000)

The PIU, created in Afghanistan to manage the delivery of the BPHS through NGO contractors, is staffed with Afghan consultants who the MoH hires and manages. The PIU has been credited with boosting the MoH’s credibility to manage significant resources. Anecdotal evidence indicates that, as in Mozambique, disparities in power and income between PIU consultants and MoH staff have created some problems within the state bureaucracy, but observers maintain that so far these have been successfully negotiated in Afghanistan. The extent to which the inherent tensions in this setup can be managed over time and its impacts on broader systems bear watching.

Creating state ownership and accountability would appear to favor improvements in institutional structures for project management over standalone PIUs (Montes and Wolfe 2000). At very least, a “sunset clause” and process for sustainable integration of PIUs is advisable (Shiavo-Campo 2003).

Decentralizing aid. Given the very limited capacity at central *and* provincial levels, few alternative startup structures may have been possible in Afghanistan. The centralization of authority that they imply may or may not have long-term impacts on MoH effectiveness. But it *is* having immediate impacts at the provincial level where service delivery takes place.

As described above, significant asymmetries in resources and capacity between NGO and provincial health entities have been reinforced by the structure of performance-based contracting arrangements in Afghanistan. At issue is the possibility that NGO resource pre-eminence will undermine local governance and, at the same time, weaken important ties to Kabul (AREU 2004). Even in the planning stage, a criticism from Afghanistan and Cambodia has been that the provincial health departments were not involved enough (AREU March 2004; Strong et al. 2005).

Whether decentralizing contract management will be a realistic (or desirable) option remains an open question. Capacity building for provincial health authorities is limited at present to efforts in some USAID-funded provinces to establish coordinating committees. More ambitious plans to build broad provincial government capacity suffered a recent setback when, under pressure from the central government, the World Bank withdrew its support for a proposed provincial strengthening initiative.

Research in Afghanistan to date has largely sought to understand the relative benefits of various contracting mechanisms. More needs to be understood about building an appropriately decentralized regulatory role for the health sector.

Structural Adjustment. Structural adjustment-driven restrictions have delimited hiring in the MoH in Timor Leste. The tiny staff at the central and provincial levels is reportedly a significant constraint to progress both in the health sector and in the MoH’s ability to play a national stewardship role. Adjustment conditionalities are similarly blamed for capacity (and salary) limitations in the public service delivery sector in Mozambique (Montes and Wolfe 2000), a point that is discussed below.

Van Diesen (1999) suggests that aid dependence and indebtedness have undermined sovereignty in Mozambique. Montes and Wolfe (2000) add:

The fact that Mozambican public finances are highly dependent on foreign aid has contributed to a situation in which the Government has spent considerably more time being attentive to donor demands (particularly from the Bretton Woods Institutions) than being attentive to and consulting its own citizens and taxpayers.

A comparison between the shortfalls in available government financing for the health sector, and substantial resources available for international technical expertise is concerning as well.

Cultural issues on the state side

Ministries of Health, like aid agencies, are bureaucracies with their own set of norms and propensities to garner and protect control over power and resources. A glimpse into foreign assistance’s effects on the culture of state health bureaucracy is valuable insofar as resilience, efficiencies, and leadership are shared goals.

In an effort to survive the unpredictability of resource flows and changing donor interests, bureaucracies in Cambodia and Mozambique are characterized as passive and unable to

prioritize their own agendas (Brown 2000; HLSP 2003; Pavignani and Colombo 2001). In Mozambique, where civil servants spent so many years protecting their institutional culture and the rules to hold it together through years of conflict, there is a deeper a resistance to change. By contrast, bureaucracies in Afghanistan and Timor Leste, beginning with a cleaner political slate, were demonstrably less risk averse, at least in the early days. Indeed, key leaders in both contexts were cited as instrumental in challenging and driving major decisions in the health sector in the early design process.

Government resistance to contracting with NGOs emerged as a noteworthy pattern in the literature and interviews. The decision in Timor Leste to assert control of non-state providers that dominated the health sector post-conflict was outlined above. In Afghanistan, recent indications are that the new, post-election MOH leadership is redefining contracting to NGOs as more of an interim measure (a perspective aid agencies do not appear to share). In Bangladesh, where government contracting to NGOs has a long history, resistance to outsourcing is reportedly chronic. In the Punjab in Pakistan—site of the only truly homegrown NGO contracting program--the initiative for an ambitious contracting program came from a chief minister. Nonetheless, it reportedly met with considerable skepticism from the MoH. In Cambodia, where the model has demonstrated remarkable health impacts, the government has agreed to let the scheme go forward in 11 remote operational districts, but has reportedly expressed its discomfort about relinquishing resources to international NGOs. Whether this resistance is simply part of the nature of bureaucracies to covet resources, prestige and turf, the very real limitations that the contracting model places on opportunities for patronage and corruption, or the possibility that ministries of health are more conservative than other parts of government, this trend bears closer consideration.

Human resources for health

Previous sections have outlined the detrimental effects of project-based aid on coherence in the health sector. Bottlenecks to service delivery, encountered by global health funding mechanisms such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunization, have surfaced a renewed focus on the importance of systems strengthening. Effective service delivery relies on durable accountable procurement, logistics, and planned financial and supervision systems; the individual and collective performance of these systems are a good bellwether of state stewardship. This section considers one of these systems.

Human resource development is a critical need in early recovery states. While the literature review did not identify a best practice solution in an early recovery situation, the advisability of an early national human resource plan is clear. In Timor Leste, the failure to develop a human resource development plan at the start is blamed on an overwhelmed DHS, and external inputs deemed “too academic” (Tulloch et al. 2003). On the other hand, early policy development focused very much on the human resource in Afghanistan. National policies for salary levels and human resource development have already been approved (Strong et al. 2005). Even so, questions are now arising about staffing realities to deliver the nationally sanctioned BPHS (Strong et al. 2005). Cambodia has faced similar human resource constraints on top of resource limitations to achieving its basic package of health activities (WHO 2002).

Wages and benefits. Attention to wages and working conditions surfaced as an important and under-prioritized issue as well. In general, health workers in all contexts are able to command higher wages than other service providers.

In Mozambique, as in Ethiopia and Rwanda, salaries of public providers were paid throughout the respective conflicts, which enabled a skeleton health delivery system to continue to operate and be revived more quickly post-conflict (Macrae 1997). Given fierce state commitment to

social services in the post-independence era, it is disturbing to note the drop in health worker wages in Mozambique over the last decade, based on adjustment-related demands from the International Monetary Fund. Between 1991 and 1996, the monthly salaries of publicly employed nurses dropped from \$110 to \$40 and doctors' salaries from \$350 to \$100. At the same time and for the same reason, the reliability of service delivery essentials such as materials, pharmaceuticals, and equipment upkeep diminished—eroding both quality services and staff morale (Pfeiffer 2003). Low public sector wages have been credited with a migration of managers and providers alike to NGOs (where salaries average \$500-1,500/month) and the private sector and spurred under-the-table charging (Monte and Wolfe 2000; Pfeiffer, 2003). Under these conditions, it is not surprising that one expert compares getting a job in an NGO to “winning the lottery.” By the late 1990s, with the public sector hemorrhaging professionals and wages dropping, nurses went on strike. The MoH appealed to the Ministry of Finance, which had resisted previous appeals because of adjustment conditions. Although the crisis led to salary hikes and more training for both teachers and medical staff, there are concerns that this may be too little too late (Brown 2000).

In Afghanistan, a series of provincial health system studies found that low and unreliable salaries presented the biggest obstacle to better performance and morale. Many health staff have two or three sources of income: MoH salary (which to date has been erratic); “incentive payments” by NGOs (sometimes given to professionals only and not administrative staff); and earnings from private practice (AREU April 2004). NGO top-ups may be distorting local markets (Byrd 2001). Health provider salaries are reportedly the highest of any other civil servants in some districts. This has reportedly lowered morale and recruitment among providers in other sectors, including teachers. Some worry whether these raised expectations might backfire down the road—and on whom (AREU April 2004; Byrd 2001).

Even in Timor Leste, the propensity in this direction was caught early by the Interim Health Authority (IHA), but not quite in time. Inflated salaries paid by the UN and other institutions in the post-conflict period distorted the labor market and recruitment for the civil service (Rohland and Cliffe 2002).

As in many contexts, low wages for health workers in Cambodia are linked to under-the-table payments and a propensity for publicly employed providers to spend much of their time in private practice (HLSP 2003). Asian Development Bank (ADB)-supported research on contracting out health services considered the impact of a per-client financial incentive for public providers in return for a ban on private practice. Improvements in public services in the study localities revealed that a modest differential in wages would more than compensate for under-the-table charges that pull providers out of the system and inflate costs to consumers (Bhushan et al. 2002). Such an analysis would seem a reasonable start to establishing wages based on market realities. The government's ability to regulate across the sector is a subsequent more ambitious task.

Community health workers (CHWs). Volunteer health workers are important in rebuilding the health system, often representing a resource already in place. In a context such as Afghanistan, where gender still prevents access to the male-dominated clinical setting for many women, CHWs (and traditional birth attendants [TBAs]) are essential; their service delivery sector role appears to be expanding. Managing and giving incentives to a large fluid cadre of CHWs is a challenge even in more stable higher capacity contexts.

CHWs have been part of the landscape for years in Afghanistan. The MoH has sought to reinstate a national program in rural areas, starting with the approval of a standardized training curriculum. CHWs are not formal members of the government health service in Afghanistan or in Timor Leste, however. Decisions about mobilizing and giving incentives to CHWs have so far

been left up to individual NGOs in Afghanistan. In both contexts, informants recognized the limitations on already stretched service sites to provide effective training, and supervision to CHWs. In Afghanistan, the MoH recently reached a decision to add a CHW supervisor to the staff in the Basic Health Service. This is seen as a positive sign.

Perspectives. The cases point to the wisdom of prioritizing the early development of a national health employment scheme. Three criteria for such a scheme stand out: 1) it reflects the larger vision for the sector; 2) it is budget-based; and 3) it is realistic in terms of capacity and capacity-building options. Importantly, the national plan should offer public managers and providers a living wage and restrict gross imbalances with the private sector. Working conditions, positive supervision, and other non-monetary incentives are important performance incentives,¹⁹ as in any service delivery system.

Resources currently used to give incentives to officials and providers to participate in project activities could be effectively reapplied to improve wages and working conditions for public providers and managers (Pfeiffer 2003). The performance-based human resource system in Afghanistan should be studied further (see below).

Rebuilding infrastructure.

With enormous resource flows characterizing the reconstruction phase, the dual imperatives for spending and visibility have led to perverse incentives for one-off projects. The so-called quick impact projects (QIPs) often take the form of infrastructure—a clinic, a school, or a drinking water system, for instance. While these types of projects are considered variously in the literature as a high-visibility peace dividend (Berry et al. 2004; Meagher 2005), increasingly they are viewed as a series of high-cost disjointed investments with the potential for backfiring if unsustainable (Macrae 1997; Pavignani 2005). The cases support this view.

In the early 1990s in Cambodia, while visible activities like infrastructure received a disproportionate share of the largesse of foreign donors, some essential activities such as malaria control and drug distribution remained under-funded. Training and broader systems development was ad hoc (Lanjouw et al. 1999). Pavignani and Colombo (2001) regard the United Nations High Commissioner for Refugees (UNHCR) behemoth reintegration effort in Mozambique as “a sledgehammer to crack a nut,” citing inappropriate infrastructure QIPs as wasteful and unsustainable. What plagued these efforts was the lack of a policy or planning framework. With the lessons of these cases still fresh, the Timor Leste Interim Health Authority moved quickly to sketch out such a framework, saying “no” to some inappropriate infrastructure projects—even to the extent that NGO work in progress on hospitals and other facilities was halted mid-project (Tulloch et al. 2003).

Conclusions. In all four countries, a significant portion of the population still relies on non-regulated health services. Government capacity to manage and regulate remains weak in all contexts, particularly at the district or provincial level. Management and clinical capacity in the NGO sector rivals or even dwarfs the state’s because of better salaries, perks, and adjustment-imposed caps on public sector salaries. External resources continue to flow largely “off budget,” in abbreviated time horizons. A small army of expatriate advisors and aid workers manage significant resources and offer sometimes-disparate advice to fragile MoHs. The powerful arm of foreign assistance appears to have induced a certain level of passivity in ministries of health in Cambodia and Mozambique, which themselves have fragmented based on donor alliances. This phenomenon has undermined coherence within Ministry of Health, as well as inter-

¹⁹ A study in South Africa showed that improved working conditions for nurses would be equivalent to 35 percent increase in salary in terms of value placed/retention (anecdotal reference 2006).

ministerial accountability relationships (in particular with ministries of finance or planning, or parliaments), all vital linkages for good governance (Brown 2000; Pavignani 2005).

There are hopeful counterpoints to these trends and notable exceptions on both sides. Broadly speaking, there is a greater appreciation of the need to anticipate state-building opportunities even in the humanitarian phase,²⁰ alongside growing recognition (and incremental action) of the importance of “harmonization,” including perhaps most challenging, alignment of donor systems to government systems (ODI 2004; OECD 2005). Some form of a sectoral plan that seeks to move beyond information sharing towards greater complementarity with government leadership is evident or underway in the health sector in all contexts. A suite of comprehensive policies continues to evolve alongside operational service delivery models. Joint funding mechanisms that provide accountable budget support have a place in each country’s health sector. The demands of the HIV/AIDS epidemic are driving a broader systems approach to the health sector (Garrett 2005). In the countries under study, government leadership appears to be coming more into its own. Taking the broad sweep of things, progress appears to have less to do with vast resources than politics, leadership, and the flexibility and accountability-focus of the respective donor and state bureaucracies.

The following section provides additional information on models and approaches now being applied in early recovery states. These models are compelling in a fragile states context because they serve to boost resilience and strengthen the state’s ability to lead and effectively manage its compact with the health delivery system. Early recovery states offer an opportunity to continue to refine promising state building approaches with an eye to their adaptation, as appropriate, in the more problematic arrested and deteriorating development fragile state contexts.

3.4 Promising approaches for supporting state stewardship

The following approaches will be summarized here, including issues for further investigation.

1. Alignment
2. Budget support
3. Performance reform program
4. BPHS
5. Contracting with NGOs
6. Equity Funds
7. Monitoring the long route of accountability

Sequencing is important in an early recovery context. Plans and resources should be prepared, even if rough, to inform service delivery mechanisms. Sectoral plans were covered earlier.

Alignment

As discussed above, when aid and government systems and policies are aligned, government tends to be able to play a greater leadership role. The reciprocal is also true of course—

²⁰ The Rome Declaration on Harmonization provides internationally agreed-upon principles and procedures for donors: respect partner priorities; provide donor coordination leadership; reduce transaction costs; and improve aid effectiveness through harmonization and alignment to enhance local ownership of policy and programs. OECD (2005) proposes this as a framework to monitor donor behavior.

government leadership improves the probability of donor willingness to align. Fiscal alignment is arguably the most important and the most challenging. Aid alignment options range from the minimum “on planning”—in which the MoH (and MoF) are notified of pledges, SWAp commitments, and other pipeline resources—to “on budget”—which implies ongoing budgeting, disbursement, and reporting by aid agencies to the government, consistent with government cycles and systems. Short of providing direct budget support, “on budget” alignment can bolster state legitimacy and effectiveness in early recovery contexts by: 1) increasing systems efficiencies; 2) increasing government accountability (“on parliament”)—a strengthening of the long route of accountability between taxpayers/voters and government; 3) leveling the playing field for donors vis-à-vis governments—desirable in “high willingness” contexts. Liabilities, of course, relate to fiduciary risks, although to date there has been no empirical evidence to compare “on” and “off” budget risk (Pavignani et al. 2002).

Budget support

Budget support shares many of the advantages of alignment, listed above. It improves the predictability of aid flows and empowers state decisionmaking. Budget support requires donors to relinquish attribution, but puts them at the table in broader, more coherent policy discussions with government and other donors. Lessons from multilateral mechanisms such as the GFATM—where resources are government-managed—may be relevant here.

Performance-based reform

The Priority Reform and Restructuring (PRR) Program in Afghanistan shows promise as a model for addressing the salary and human resource accountability issues that challenge public service delivery and the bureaucracy’s ability to play a regulatory role. The early recovery phase is an advantageous moment to put in place new performance-based human resource systems. In Afghanistan, the PRR is designed to enable ministries to recruit needed capacity in the rebuilding phase, while establishing institutionalized performance-based cultures in the civil service. Positions are filled by competition and an independent body makes appointments to ensure transparency (ADB 2005).

The ambitious PRR process is proving highly labor intensive in Afghanistan, with quarterly performance appraisals. The benefits in terms of quality services, systems efficiencies, and health outcomes by rewarding performance bear watching.

Basic package of health services

A basic package of services (or activities) is used in early recovery contexts to standardize service delivery. Defining a BPHS has obvious benefits for rationalizing training, monitoring, and supervision systems based on a set of national standards. BPHS may also enable the integration of vertical programs. It provides a framework for introducing international best practices. The BPHS adoption was an integral part of designing the contracting mechanism and benchmarking for both cost and performance indicators in Afghanistan. In Cambodia, a minimum package of activities for health centers and a complimentary package of activities for district hospitals have been in effect since 1995.²¹

In the early recovery phase, when the human resource or other systems are insufficient to launch the BPHS, prioritizing and phasing-in BPHS components, based on needs and capacity may be appropriate (Strong et al. 2005). There are also questions about whether this “one size

²¹ By 2002, the minimum package of activities was offered at 82 percent of health centers and the complimentary package of activities at 40 percent of 48 provincial and district hospitals (Flint 2004).

fits all” approach is appropriate in a country with geographic, cultural, or resource diversity. In such circumstances, local adaptation might be considered.

Contracting with NGOs

Recognizing the important contribution that non-state providers will continue to make in service delivery and rebuilding the health sector, early recovery efforts must rationalize a relationship of the private sector with the state that enhances state stewardship (minimally, in a regulatory role).

Nearly every health system in the world relies on contractors to deliver or support some of the services it provides. Contracting to NGOs has been used in developing countries to achieve broad coverage—sometimes in the millions of clients—target specific services (e.g., primary health care or nutrition), improve efficiencies and equities, and lower costs to consumers. Proponents of this approach cite a number of advantages including: 1) an emphasis on measurable results; 2) responsiveness to consumers; 3) the potential for improving and decentralizing management autonomy; 5) competition that increases effectiveness; and 6) focusing government on standard setting, regulation, and financing rather than on delivery. Skeptics raise concerns about high transaction costs, government capacity to manage and monitor contracts, and the cost of NGO services compared to that of the public sector. A comprehensive data analysis on NGO contracting in the health sector points to: 1) more success when contractors have greater autonomy; 2) more success when accountability is based on outputs rather than inputs; 3) significantly greater economies of scale over 500,000 beneficiaries; and 4) greater management efficiencies when the number of contractors is minimized (Loevinsohn and Harding 2005).

More investigation of these points is important and is underway in the countries under study and beyond. The intersection of this model with health reform and decentralization, including the role of provincial health authorities in national contracting schemes, bears particular attention.

Equity funds

The equity fund, in a trial period in Cambodia, offers a promising model for widening the safety net in the face of soaring of health costs. NGO contractors (many of them local religious organizations) identify fund beneficiaries (in this case, the poorest members of the community) through consultation with community members. Contractors pay user fees on members’ behalf for catastrophic, obstetric, or debilitating illnesses. The fund has reportedly been more successful in targeting the poor than broader subsidies to the public sector and is viewed as a precursor to the MoH’s goal of establishing a social health insurance scheme (ADB 2004; Jacobs and Price 2005). The equity fund model has significant appeal for an early recovery context where inequities in access based on resources exist. To succeed, it relies on community cohesion and a network of trusted community-based managing entities.

Monitoring the long route of accountability

Tracking the long route of accountability between the state and the health system requires a marriage of traditional epidemiological indicators and broader measurements of governance and resilience. The Ghani et al. (2005) sovereignty scorecard offers one of a number of indicator lists for monitoring state building and a possible macro indicator starting point for a “sovereign health system.” The sovereignty scorecard includes a list of these 10 key functions:

1. A legitimate monopoly on the means of violence
2. Administrative control
3. Sound management of public finances

4. Investment in human capital
5. The creation of citizenship rights and duties
6. Provision of infrastructure
7. Market formation
8. Management of the assets of the state
9. Effective public borrowing
10. Maintenance of the rule of law.

While this list is designated for the state, many of the same functions apply to the health system itself.

A health system “resilience scorecard” could include practical management indicators for measuring access, accountability, alignment, capacity, coherence, coverage, and equity in the health system.²² Such a scorecard would, by necessity, capture the entire health system, including all institutional participants, delivery mechanisms, and critical linkages to other internal state and non-state stakeholders. A donor performance scorecard based on the commitments of the Rome Agreement would be equally valuable with the possibility for sending an empowering, reciprocal accountability signal to the Ministry of Health.

4 Strengthening legitimacy: the long route of accountability through civil society

The long route of accountability tracks the state’s responsiveness to its citizens who are also consumers of the services that it is committed to ensuring. It describes the state’s ability to hear consumer demands and respond accordingly. It is, therefore, an important factor in citizen’s perception of government legitimacy. Civil society is, broadly speaking, the mechanism for state-constituent interaction. It may include all the democratic institutions that enable this interaction between the state and its citizens. For the purpose of this discussion, civil society focuses on NGOs (also called civil society organizations)—as one of the agents for consumer voice. The literature has not specifically tackled the impacts of foreign assistance on this complex relationship in the service delivery sector, and much of what is presented here is inferred.

4.1 Legitimacy issues

Legitimacy depends on *expectation*. In a recent survey, Northern Sudan citizens ranked health care, education, employment (urban areas), and agriculture (rural areas) as post-conflict priorities for government attention. Interestingly, even in conflict areas, these concerns outranked settling ethnic conflicts and security issues (National Democratic Institute 2005). Health and education were centerpieces of the socialist-leaning government of Mozambique following independence in 1975. The provision of primary health care and a rapid expansion in service delivery endowed the new Mozambican government with popularity and legitimacy. It was for just this reason that clinics and schools became a target for the Rhodesian-based

²² An “Afghanistan Health Sector Balanced Scorecard,” developed by the MoH, Johns Hopkins University, and the Indian Institute for Health Management Research (2004), benchmarks the BPHS delivery—as a start. The scorecard proposed here would include an assessment of the resilience of systems necessary to support the BPHS and broader governance indicators that shape legitimacy and effectiveness, as mentioned above.

RENAMO insurgency in (1976-92) in its efforts to destabilize the country. Health workers and teachers were murdered, maimed, and kidnapped. By the end of the conflict, one-third of the facilities were destroyed (Pavignani and Colombo 2001). Health workers were also the Khmer Rouge's target, though the decimation of the population of professionals across the board was more complete in Cambodia than in Mozambique. In Timor Leste, social service infrastructure was also a target for the departing Indonesian military, though its destruction happened over a period of several weeks.

The restoration of social services was an important factor in signaling a return to normalcy and a functioning government in Mozambique and Timor Leste—both places where the population had expectations of receiving social services from the state (Pavignani and Colombo 2001). On the other hand, one expert conjectures that, in contexts where populations are not used to receiving or expecting services from the state, security may supersede health as a legitimizing factor. This may remain the case in Afghanistan.

4.2 Politics and health as a peace bridge

Humanitarian assistance in most conflict and post-conflict settings operates on the political neutrality principle. Yet it is well documented that aid can become politicized. Food assistance became a tool for warring parties, even aggravating tensions in Haiti, Mozambique, and Rwanda, for instance. (USAID 2001)

In Mozambique, efforts to reintegrate RENAMO health workers into the health workforce promoted reconciliation (Pavignani and Colombo 2001). Days of Tranquility for immunization campaigns, first used in El Salvador in 1985, have been advanced as an example of a peace bridge (WHO 2002).

But the impact of health services on making or keeping the peace or making a new government legitimate remains largely anecdotal (WHO 2002). Indeed, the opposite may be more to the point. Without a political solution that guarantees stability, a health system cannot get much traction (Pavignani and Colombo 2001). External assistance to rebuild the health sector began in Cambodia, Mozambique, and Timor Leste at the end of the conflict. It is instructive to note how much momentum was possible in rebuilding the health sector in Mozambique and Timor Leste, given the internal political cohesiveness in the post-independence era. In Timor Leste, in less than two years a Department of Health was established under the second transitional government (September 2001). Importantly, DHS leaders maintained an ongoing exchange with political leadership throughout the early period. Although there were differences of opinion, the consistent interaction is credited with part of the rebuilding effort's success, even when compared with other sectors (Rohland and Cliffe 2002). Similar politically empowered cooperation was seen in Mozambique in the early days, as mentioned above (Pavignani and Colombo 2001).

On the other hand, aid in general and health services in particular may be a "blunt instrument" in achieving a political or diplomatic solution. In a prescient pre-9/11 piece on aid as a peace-building mechanism, Goodhand and Atkinson (2001) stress the limitations of humanitarian and development assistance in addressing a conflict's political roots. They cite Afghanistan as a place where aid was the international community's "smokescreen for inaction." During the Taliban period, the international community developed a strategic framework for the health sector, but political debates about whether to engage or cease activities with the Taliban regime forestalled realization of the plan (Sondorp 2004).

Conflict, including a foreign military presence, remains a feature of rebuilding efforts in Afghanistan. The re-establishment of health services in Afghanistan is broadly viewed as supportive of wider efforts to stabilize an inherently unstable situation, bolstering the new

government's legitimacy²³ (Natsios 2004). Following this reasoning, if health is a peace bridge, premature declines or even severance of aid to the health sector would contribute to a disruption of the fragile stasis. Afghanistan—where 90 percent of aid comes from foreign assistance—may be quite vulnerable in this regard.

4.3 Civil society organizations

Donors and civil society organizations

Donors look to NGOs as important agents in democracy building—enhancing the long road of service delivery accountability by holding policy makers and even service providers accountable to consumers through awareness raising, demand creation, and advocacy.²⁴ As discussed above, donors also rely on NGOs to address service delivery gaps. A civil society's ability to achieve broad sustainable advances on behalf of marginalized constituents may be compromised by split expectations in this regard. In their study of Afghanistan, Liberia, and Sri Lanka, Goodhand and Atkinson (2001) reflect on this phenomenon:

The aid regimes in all three countries are donor-dominated because of the power and resources they wield. This is increasingly becoming the case as NGOs become the contractors for official aid agencies, thus silencing the potential “dissident voices” within the aid system. In Afghanistan, this comes out very starkly, whereby donor agendas shape the entire system, from the UN downwards. Distortions work their way down the system and NGOs have limited capacity to counteract an environment of politicization and confrontational conditionality.

While this was written before NGOs were formally enlisted as the state's service delivery agents, it raises important questions about whether and how the new NGO role as contractor might supersede expectations of a broader civil society activism for NGOs. In fact, early in the discussions, some NGOs raised concerns about the loss of autonomy that a contractual arrangement would entail (AREU March 2004). Despite their important service delivery role in Afghanistan, NGOs were excluded from early consultations on a health sector strategy (Strong et al. 2005).

The state and civil society organizations

Donors may fuel the growth of the non-state sector, but governments also play a role. The governments studied here have their own set of suspicions about homegrown NGOs (which have proliferated over time in response to market forces) and have sought in different ways to delimit the space for NGOs as civil society agents. In the past, tensions between NGOs and government tended to focus on voice, rights, and participation in the political process. As alluded to above, today the tension may be more about control over resources and the political leverage this imputes. Insofar as service delivery efficiencies are a legitimating force, it is no wonder that governments feel this way. As state-avoidance strategies drive resource flows into the non-state sector, weak or weakening public sector capacity becomes part of an unhelpful self-fulfilling rationalization on the part of donors for continued state circumvention. It also underscores state suspicions about civil society. In Cambodia, Mozambique, and even

²³ Aid is an integral part of the U.S. government's three-pronged anti-terrorism strategy in Afghanistan

²⁴ NGOs also operate as “surrogates” for direct political engagement. In some cases this is because countries are not perceived to have strategic significance to the level requiring direct engagement. In some it is because government partnerships are too politically difficult, as mentioned above (Goodhand and Atkinson 2001; Pavignani and Colombo 2001).

Bangladesh, where a thriving NGO sector has made significant impacts on health and reproductive health nationally, ministries of health have resisted NGO participation in sectoral strategy dialogue precisely because of resource and leverage asymmetries (Brown 2000; van Diesen 1999).

A third track

NGOs are not a homogeneous group. Local and international NGOs are broadly distinguishable in terms of differences in accountability, resource networks, and even operational styles. While INGOs have become part of the landscape in most fragile states for the reasons described above, it is the local “civil society” organizations that, in the longer term, will remain to continue to mobilize the demand side of the long road of accountability. While INGOs are an important training ground for future NGO clinicians, managers, and leaders, when NGOs are not co-opted as subcontracting partners, they are also competitors in the same aid marketplace.²⁵ This is the case in Afghanistan and Cambodia.

Perspectives. NGOs will continue to play an important service delivery sector role for years to come. Repositioning strategies that enable greater alignment with, and support to, state efficacy in the health sector are important for ongoing work in fragile states. NGOs are likely to remain or continue to proliferate in their service delivery role in response to donor resources. Alignment with government systems, while vital to state efficiencies, may compromise an independent civil society role, which is also vital for state legitimacy. Health programming in early recovery contexts will benefit from an analysis that is explicit and appropriate in its expectations of non-state providers.

²⁵ Interestingly, in Afghanistan, observers note that local NGOs are perceived as delivering better services at lower cost and willing to stay open with greater predictability in insecure situations (Rohland et al. 2002).

5 Conclusions

The brief history of post-conflict recovery efforts in these early recovery states points to some significant structural obstacles in the way of aid assistance to systems strengthening in fragile states. In particular, it raises concerns about the extent to which foreign assistance has undermined, externalized, or, at minimum, fragmented the service delivery sector's accountability. Fragile states are defined by fragile and sometimes unaccountable systems and capacity. In early recovery states where the goal is improved state legitimacy and effectiveness, nurturing state stewardship of the health sector depends on a donor community that is willing to stand together and behind the state to build systems and capacity over a realistic timetable. Based on the cases reviewed, this seems to rely on a number of factors:

1. A sectoral framework with built-in conditionalities
2. Long-term, inclusive, multi-donor funding managed through an intermediary or government or donor mechanism
3. Long-term, systems-based capacity building for adequately paid MoH managers and service providers;
4. NGO accountability to the state
5. Technical assistance as mentoring, not doing for.

While the current approach has resulted in improvements in some health indicators, sustainable improvements in these indicators will rely on improvements in the ability of state institutions to manage and monitor resources and to respond to the expectations of consumers and the health system requirements as a whole.

Table 1 summarizes some trends in early recovery contexts that this report highlighted. Table 2 presents a summary of promising approaches in a sequenced format.

Table 1: Foreign assistance in the immediate post-conflict and transitional phases

Unhelpful trends	Helpful trends
<ul style="list-style-type: none"> • State-avoidance strategies that establish parallel service delivery bureaucracies and stay too long • Relief efforts that inflate salaries and expectations, and pull capacity out of the civil service • Providing too many resources in terms of relief efforts that are out-of-sync with planning or absorptive capacity • High-visibility, unsustainable, one-off infrastructure projects 	<ul style="list-style-type: none"> • A common donor framework for planning and action • Budget support that helps to stand up government functionality • Continued wages to state health providers • Early inventories of facilities and human resources • Epidemiological studies when little is known about health status • MoH engagement with political leadership

Table 2: Foreign assistance in the development phase

Unhelpful trends	Helpful trends
<ul style="list-style-type: none"> • State-avoidance strategies that fragment service delivery without reference to government systems or leadership • Local projects that divert provincial accountability from central government to external payers • Unsustainable or costly pilot efforts • Stand-alone project management units parallel to government management systems • Technical assistance that “does for” rather than mentors • Capacity building divorced from resource management 	<ul style="list-style-type: none"> • Donor harmonization of policy advice and strategies • Donor alignment with state fiscal, procurement, logistics, boundary, human resource, and salary systems • Funding mechanisms that support a coherent state-led approach to service delivery • Disbursement frameworks with built-in conditionalities

Promising approaches for the health sector in early recovery fragile states

Sequencing is important in an early recovery context. A practical planning framework, with achievable short- and medium-term targets and the resources to achieve targets should be confirmed before service delivery strategies are rolled out.

Table 3: Sequencing in Early Recovery

Promising approaches	Perceived or demonstrated benefits	Issues and challenges
Key studies in early recovery	<ul style="list-style-type: none"> • Basic epidemiological, facility, or human resource studies inform planning • Promote shared frame of reference among multiple stakeholders 	<ul style="list-style-type: none"> • Depth/rigor versus the need for quick information
Sector planning frameworks	<ul style="list-style-type: none"> • Encourages donor harmonization • Enables donor-government policy dialogue • Reduces fragmented project-based aid • Rationalizes resource allocations (if accompanied by budget commitments) • Establishes performance targets for governments and donors 	<ul style="list-style-type: none"> • Most effective under government leadership; barring this, a donor or intermediary that all stakeholders trust and follow • Engaging all levels of government, civil society, private sector, and donors is critical, especially in the transition period • Outcomes diluted without reliable funding streams. • Requires reconciling divergent donor accountability and attribution requirements
Trust Funds	<ul style="list-style-type: none"> • Harmonizes approaches and systems among contributors • Rationalizes resource allocation based on joint donor/government plans • Built in accountabilities and conditionalities • Reduces transaction costs following initial start up investments 	<ul style="list-style-type: none"> • What happens when all donors don't participate? • Is it appropriate for governments lacking a pro-poor orientation to service delivery? • Dilutes attribution, though relatively greater attribution options than global health funds
Pooled funding for specific services	<ul style="list-style-type: none"> • Enhances donor-government coherence and government accountability • Reduces transaction costs • Aligns budgeting with expenditures. 	<ul style="list-style-type: none"> • Opportunities for broader impact on government financial, logistics, and service delivery systems • Dilutes attribution, as above
Basic package of services	<ul style="list-style-type: none"> • Standardizes service, human resource, and cost structures 	<ul style="list-style-type: none"> • May set the bar unrealistically high • May ignore geographic, demographic, epidemiological, or capacity variations in coverage area
State contracting to NGOs for service delivery	<ul style="list-style-type: none"> • Organizes non-state service delivery under government regulation • Standardizes service delivery package • Demonstrated cost, coverage, and equity efficiencies in a variety of contexts 	<ul style="list-style-type: none"> • Requires some essential government capacities and systems to adequately manage contractors—at national and provincial/district levels. • Viability of this model depends on a threshold private sector service delivery capacity. • Cost and sustainability questions arise when main contractors are INGOs versus local NGOs or local for-profit providers. • Contractual relationship may compromise the ability of NGOs to act as civil society agents
Equity funds	<ul style="list-style-type: none"> • Widens safety net for the poorest by direct payment for catastrophic illness • Seeds national health insurance • Addresses equity and access imbalances 	<ul style="list-style-type: none"> • Management issues similar to state contracting of NGOs

Participants consulted for this paper

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Bibliography

- Berry, Chris, Ali Forder, Sonya Sultan, and Magüi Moreno-Torres. "Approaches to Improving the Delivery of Social Services in Difficult Environments." *Poverty Reduction in Difficult Environments (PRDE) Working Paper 3*, DFID, October 2004.
- Birdsall, Nancy, Dani Rodrik and Arvind Subramanian. "How to Help Poor Countries." *Foreign Affairs*, July/August 2005.
- Borton, John. An Account of Coordination Mechanisms during the International Response to the 1994 Crisis in Rwanda. *Disasters* 20(4): 305-24, 1996.
- Brugha, Ruairi, Mary Starling, Gill Walt, and Martine Donoghue. "Tracking the Global Fund in Four Countries: An Interim Report, Draft 2." London School of Hygiene & Tropical Medicine, UK, 2003.
- Buse, K. "A Policy Analysis of Aid Coordination and Management in the Health Sector of Bangladesh: Assessing the Instruments, Exposing the Agendas and Considering the Prospects for Government Leadership." Unpublished Ph.D. diss., University of London, 1999.
- CDIE (Center for Development Information and Evaluation) and USAID. *CDIE Impact Evaluation: Providing Emergency Aid to Mozambique*. Washington, DC: CDIE and USAID, June 1999.
- Christiansen, Karin and Andrew Rogerson. "Is the current aid architecture 'fit for purpose'?" Overseas Development Institute for the Commonwealth Finance Ministers Meeting, Barbados, September 18-20, 2005.
- Collier, Paul, and Anke Hoeffler. "Aid, Policy & Growth in Post-Conflict Countries." World Bank, February 2002.
- Easterly, William. "The Cartel of Good Intentions: Bureaucracy Versus Markets in Foreign Aid." Center for Global Development, Institute for International Economics, May 2002.
- Eichler, Rena, Paul Auxila, and John Pollock. "Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti." *World Bank Institute Online Journal: Flagship Program on Health Sector Reform & Sustainable Financing*, World Bank, April 2001.
- Garrett, Laurie. "The Lessons of HIV/AIDS." *Foreign Affairs* Vol 84 Number 4, July/August 2005.
- Ghani, Ashraf, Clare Lockhart, and Michael Carnahan. "Closing the Sovereignty Gap: An Approach to State-Building." ODI (Overseas Development Institute), London, September 2005.
- Goodhand, Jonathan, and Philippa Atkinson. "Conflict & Aid: Enhancing the Peacebuilding Impact of International Engagement A Synthesis of Findings from Afghanistan, Liberia & Sri Lanka." *International Alert*, July 2001.
- HLF (High Level Forum) on the Health MDGs, "Achieving the Health Millennium Development Goals in Fragile States." Abuja, December 2004.
- Hutton, Guy. "Indicators for Monitoring Health Sector Reform & Sector-Wide Approach." Paper presented at the Sector-Wide Approach in Health Conference, "Moving from Policy to Practice," Royal Tropical Institute, Amsterdam, November 27-28, 2000.

- Johns Hopkins University, Ministry of Health of Afghanistan, and the Indian Institute for Health Management Research “Afghanistan Health Sector Balanced Scorecard.” 2004.
- Kumar, Krishna, and Marina Ottaway. “From Bullets to Ballots: A Summary of Findings from Six Post-Conflict Election Studies.” Paper presented at a USAID Conference Promoting Democracy, Human Rights, and Reintegration in Post-conflict Societies, October 30-31, 1997.
- Leader, Nicholas, and Peter Colenso. “Aid Instruments in Fragile States.” Working draft for consultation, Poverty Reduction in Difficult Environments Working Paper 5, DfID (Department for International Development), January 2005.
- Loevinsohn, Benjamin, and April Harding. “Buying Results? Contracting for Health Service Delivery in Developing Countries.” *Lancet* (366): 676–81, 2005.
- Macrae, Joanna. “Dilemmas of Legitimacy, Sustainability, and Coherence: Rehabilitating the Health Sector.” In *Rebuilding Societies after Civil War: Critical Roles for International Assistance*, edited by Krishna Kumar, L. Rienner Publishers, November 1996.
- Meagher, Patrick. “Service Delivery in Fragile States: An Issues Paper.” IRIS Center, University of Maryland, College Park, 2005.
- NDI (National Democratic Institute). “Embracing the Promise of Peace: Citizen Views on Sudan’s Future after the CPA.” NDI, Sudan, 2005.
- ODI (Overseas Development Institute). “Incentives for Harmonization in Aid Agencies.” ODI for the DAC Working Party on Aid Effectiveness, London, 2005.
- OECD (Organisation for Economic Co-operation and Development). CRS Online Database on Aid Activities and International Development Statistics (IDS) Online Databases on Aid and Other Resource Flows. <http://www.oecd.org/dataoecd/50/17/5037721.htm> (accessed January 5, 2006).
- . “DAC Experts Meeting on Peace Building and Development in Eastern Democratic Republic of Congo in the Context of the Region of Central Africa.” Development Co-operation Directorate of the OECD. December 6, 2004.
- . “Service Delivery in Fragile States: Advancing Donor Practice. Concept Note prepared by USAID and UNICEF for the DAC Fragile States Group (FSG). June 15, 2005.
- Pavignani, Enrico. “Swamped in a SWAP? Experience-inspired Remarks about Sector-Wide Approaches.” n.d.
- . “Health Service Delivery in Post-Conflict States.” Prepared for the Secretariat of the High Level Forum on the Health MDGs, 2005.
- . “Module 12: Formulating Strategies for the Recovery of a Disrupted Health Sector, Analyzing Disrupted Health Sectors-A Toolkit: Module 12.” World Health Organization, Geneva, Switzerland, n.d.
http://www.who.int/hac/techguidance/tools/disrupted_sectors/module_12/en/index.html (accessed December 6, 2005).
- Schiavo-Campo, Salvatore. “Financing and Aid Management Arrangements in Post-Conflict Situations.” CPR Working Paper No. 6, World Bank, Washington, DC, June 2003.
- USAID (United States Agency for International Development). “Complex Emergencies and USAID’s Humanitarian Response.” *USAID Evaluation Highlights* No. 73, CDIE, Washington, DC, July 2001.

- . “USAID Fragile States Assessment Framework.” Draft prepared for use at Burundi Workshop, Washington, DC, July 27-28, 2005.
- Waldman, Ronald. “Health Service Delivery in Non Post-Conflict Fragile States.” Prepared for the Secretariat of the High Level Forum on the Health MDGs, 2005.
- Walt, Gill, Enrico Pavignani, Lucy Gilson, and Kent Buse. “Health Sector Development: From Aid Coordination to Resource Management.” In *Health Policy and Planning*. Oxford: Oxford University Press, 207–18, 1999.
- . “Managing External Resources in the Health Sector: Are There Lessons for SWAPs?” In *Health Policy and Planning*. Oxford: Oxford University Press, 273–84, 1999.
- WHO (World Health Organization). “Report on the Second World Health Organization Consultation on Health as a Bridge for Peace.” WHO, Ecogia, Versoix, July 8-9, 2002.
- World Bank, *1993 World Development Report: Investing in Health*. Washington, DC: World Bank, 1993.
- , *2004 World Development Report: Making Services Work for Poor People*. Washington, DC: World Bank, 2004.
- Zivetz, Laurie. “Health Programming in Fragile States: A Working Update on Literature and Interviews.” BASICS Project, Arlington, Virginia, November 2005.

Afghanistan

- ADB (Asian Development Bank). “Proposed Program Cluster of Loans Islamic Republic of Afghanistan: Fiscal Management & Public Administration Reform.” ADB, Manila, November 2005.
- Afghanistan Ministry of Rural Rehabilitation & Development. “MRRD Reform & Institutional Strengthening.” <http://www.mrrd.gov.af/prog/reform.htm> (accessed January 27, 2006).
- AREU (Afghanistan Research and Evaluation Unit) and the World Bank, “Case Study: Herat Province.” March 2004.
- AREU and the World Bank. “Subnational Administration in Afghanistan; Case Study: Badakhshan Province.” March 2004.
- AREU, and the Poverty Reduction and Economic Management Sector Unit, South Asia Region, the World Bank. “Afghanistan; Volume I: Assessment and Recommendations for Action, Report No. 28435-AF.” April 1, 2004.
- Byrd, William. “AID Management during Post-Conflict Reconstruction, Lessons From International Experience.” Paper presented at the Conference on Preparing for Afghanistan’s Reconstruction, Islamabad, November 2001.
- Connell, Peter, Mohammad I. Maroof, Faiz Momand, Hedayatullah Stanekzai, S. Sukrullah Wahidi, and Habiburrahman Habib. “Mid-Term Evaluation of the Rural Expansion of Afghanistan’s Community Based Health Care (REACH) Program.” Afghanistan: Ministry of Public Health and USAID, December 2004.
- European Commission: External Relations Directorate General. *National Indicative Program of European Community Support 2005-2006: Afghanistan*. 2006.
- Natsios, Andrew S. “U.S. Strategy in Afghanistan on the Eve of National Elections.” Testimony before the International Relations Committee, U.S. House of Representatives, September 29, 2004.

Sondorp, Egbert. "Case Study: A Time-Series Analysis of Health Service Delivery in Afghanistan." In *2004 DFID Report on Service Delivery in Difficult Environments*. London: DfID, DfID Health Systems Resource Center, 2004.

Strong, Lesley, Abdul Wali, and Egbert Sondorp. "Health Policy in Afghanistan: Two Years of Rapid Change - A Review of the Process from 2001 to 2003." London School of Hygiene and Tropical Medicine, London, 2005.

World Bank. "Country Brief: The World Bank in Afghanistan."
[http://www.worldbank.org.af/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/AFGHANI STANEXTN/0,,menuPK:305994~pagePK:141132~piPK:141107~theSitePK:305985,00.html](http://www.worldbank.org.af/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/AFGHANI%20STANEXTN/0,,menuPK:305994~pagePK:141132~piPK:141107~theSitePK:305985,00.html) (accessed October 4, 2005). July 2005.

Cambodia

ADB (Asian Development Bank). "Grant for Equity Funds to Help Poor in Cambodia Pay for Health Care Costs." November 2004.
<http://www.adb.org/Documents/News/2004/nr2004148.asp> (accessed January 21, 2005).

Bhushan, Indu, Sheryl Keller, and Brad Schwartz. "Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia." *ERD Policy Brief*, No. 6, Asian Development Bank, Manila, March 2002.

Flint, Michael. *Evaluation of DFID Country Programs-Country Study: Cambodia 1997-2003*. London: DfID, July 2004.

Hill, Peter. "Case Study 5: Integrating International Health Policy: Safe Motherhood, Reproductive Health, and Sector-wide Approaches to Health Development." University of Queensland, Brisbane, 2002.

HLSP. "Donor Coordination, Alignment of Assistance and Harmonization of Policies and Procedures: the Cambodian Case." Case Study for Module 4 of the Joint Donor Staff PRSP Training, Vietnam, 2003.

International Development Association and International Finance Association. "Country Assistance Program for the Kingdom of Cambodia." International Development Association and International Finance Association for the World Bank, April 18, 2005.

Jacobs, Bart, and Neil Price. "Improving Access for the Poorest Public Health Services: Insights from Kirivong Operational Health District in Cambodia." *Health Policy & Planning* 21(1): 27-39. <http://heapol.oxfordjournals.org/cgi/content/abstract/21/1/27>, November 2005.

Lanjouw, Steven, Joanna Macrae, and Anthony B. Zwi. "Rehabilitating Health Services in Cambodia: The Challenge of Coordination in Chronic Political Emergencies." *Health Policy and Planning* 14(3): 229-42, 1999.

Loevinsohn, Benjamin. "Contracting for the Delivery of Primary Health Care in Cambodia: Design and Initial Experience of a Large Pilot-Test." World Bank, Washington, DC, n.d.

Meesen, Bruno, William Van Damme, Ir Por, Luc Van Leemput, and William Hardeman. "MSF Cambodia-The New Deal in Cambodia: The Second Year—Confirmed Results, Confirmed Challenges, Cambodia." Médecins Sans Frontières and Institute of Tropical Medicine, July 2002.

USAID. *USAID Cambodia Overview*. USAID.
http://www.usaid.gov/kh/USAID_Cambodia_overview.htm, 2005.

———. *USAID Cambodia: Strategy Statement*. n.d.

Mozambique

- Beattie, Allison, and Daniel Kraushaar. "A Summary of Policy Recommendations for Health Sector Reform—Health Expenditure in Mozambique: An Analysis of Major Policy Issues." Management Sciences for Health, Family Planning Management Development Project and the Health Reform & Financing Program, 2000.
- Brown, Adrienne. "Current Issues in Sector-wide Approaches for Health Development: Mozambique Case Study." Overseas Development Institute and WHO, Geneva, 2000.
- Marshall, Katherine. "From War and Resettlement to Peace Development: Some Lessons from Mozambique and UNHCR and World Bank Collaboration." Development Discussion Paper No. 633, Harvard Institute for International Development, Harvard University, Cambridge, Massachusetts, April 1998.
- Montes, Carlos, and Toby Wolfe, with C. Cramer and H. Hallam. "Evaluation of EC Country Strategy: Mozambique 1996-2000." Investment Development Consultancy, France, and Development Strategies, Italy, 2000.
- Pavignani, Enrico, and Joaquim Ramalho Durao. "Managing External Resources in Mozambique: Building New Aid Relationships on Shifting Sands." *Health Policy and Planning* Oxford University Press, Vol 14, 243–53, 1999.
- Pavignani, Enrico, Stefan Sjölander, and Dag Aarnes. "Moving On-Budget in the Health Sector of Mozambique: Requirements, Features and Implications of Future Aid Management and Financing Mechanisms." Report undertaken for the Swiss Agency for Development and Cooperation, December 2002.
- Pavignani, Enrico, and Alessandro Colombo. "Providing Health Services in Countries Disrupted by Civil Wars: A Comparative Analysis of Mozambique and Angola, 1975–2000." WHO, 2001.
- Pfeiffer, James. "International NGOs and Primary Health Care in Mozambique: The Need for a New Model of Collaboration." *Social Science and Medicine* Vol 56:725–38, 2003.
- USAID. "General Budget Support: An Alternative Assistance Approach-Mozambique Country Case Study." PPC Evaluation Working Paper No.18, USAID, Washington, DC, August 2004.
- van Diesen, Arthur. "Aid to Mozambique: An End to Dependence? An Assessment of the Quality of Aid to Mozambique, with Special Reference to British and EC Aid for Health and Education." Christian Aid, July 1999.

Timor Leste

- Clark, Jeffrey, Ann von Briesen Lewis, and Lia Juliani. "Final Evaluation: The OTI Program in East Timor." Development Associates, Inc., Arlington, Virginia, February 2003.
- DuRette, Jean, and Glenn Slocum. "The Role of Transition Assistance: The Case of East Timor." CDIE/USAID, Washington, DC, 2001.
- MoH (Ministry of Health). "Basic Package of Health Services Policy." MoH, Timor Leste, n.d.
- . "East Timor's Health Policy Framework." June, 2002
- Rohland, Klaus, and Sarah Cliffe. "The East Timor Reconstruction Program: Successes, Problems and Tradeoffs." Working Paper No. 2, Conflict Prevention and Reconstruction Unit, World Bank, Washington, DC November 2002.

Tulloch, Jim, Fadia Saadah, Rui Maria de Araujo, Rui Paulo de Jesus, Sergio Lobo, Isabel Hemming, Jane Nassim, and Ian Morris. "Initial Steps in Rebuilding the Health Sector in East Timor." Mailman School of Public Health New York, Columbia University, 2003.

USAID. "Program Assistance: the Democratic Republic of Timor-Leste-Country Case Study." Evaluation Paper No. 5, CDIE, USAID, Washington, DC, June 2005.

———. "Strategic Plan for East Timor: A New Nation Moving Forward, 2005-2009." USAID, Washington, DC, n.d.