



Improving the delivery of health and education services in difficult environments: lessons from case studies

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Case Studies of Different Types of Service Delivery in Difficult Environments

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EXECUTIVE SUMMARY

This report summarises the findings of research carried out by IHSD into the question of how service delivery interventions can be improved in difficult environments. Evidence was obtained from a series of desk-based case studies (Afghanistan, Angola, Democratic Republic of Congo Sri Lanka, Sudan and Uganda). The following lessons have been drawn from the cases reviewed here:

Policy level:

- **Leadership and coordination:** There must be some form of overarching policy that drives service delivery agenda and ensures that there is good coordination between different actors (government, donors and NGOs/private sector). In difficult environments this leadership may need to be instigated externally at first, where national governments are unable to take on coordination themselves.

- **Involving state actors:** The case studies demonstrate that governments are not monolithic entities, and that there are numerous points of entry for working with governments on pro-poor service delivery policies and strategies. While not yet adequately evaluated there are indications that even very weak governments can help set the policy environment and work through other agencies in a contractual arrangement to ensure adequate service delivery.

- **Relief to development transition:** Building the capacity of state and non-state actors should be integrated into all programmes of work in difficult environments. By including capacity building in service delivery strategies, organisations can incorporate the long term perspective even while providing short term interventions.

- **Reaching the poorest:** DFID and its development partners must follow through on their obligations to protect the human rights of the most vulnerable groups living in difficult environments, either through direct intervention with those committing abuse or through close liaison with specialist human rights organisations by providing support for monitoring and advocacy work.

Operational Level.

- **Strategic planning and management:** Much greater attention needs to be given to building the capacity of government staff and civil society to be more strategic. This is a very neglected area that requires particular skills, which are not often available in organisations operating in difficult environments.

- **Continuous Funding:** Effective delivery of services in difficult environments requires long term funding commitments. Funding streams for humanitarian assistance and development must have a more seamless interface to avoid the short termism of humanitarian aid, and the stop/start characteristics as countries move from emergency crisis to rehabilitation and longer term development.

- **Building sustainable systems:** Sustainable systems can be nurtured within difficult environments. A starting point would be for all assistance to work from the principle that local capacity does exist, whether within communities, civil society, local or national government. Sustainability can be fostered by ensuring much greater involvement of these different levels in planning, delivering and monitoring services.

- **Reaching the poorest:** The only effective strategies for reaching the poorest in difficult environments is through targeting programmes to meet the needs of groups that are marginalised and hard to reach. This necessitates a willingness to bear the increased costs of reaching these groups while also ensuring that targeted programmes are coherent with mainstream programmes within any given context.

- **Harnessing non state providers:** Where governments are more fragile, or show weak interest in getting services to poor people alternative coordination mechanisms need to be put in place, either through the UN or other umbrella coordination organisation.

1 INTRODUCTION AND BACKGROUND

1.1 Problem statement

500 million people, “including around 200 million people living in extreme poverty” live in countries that have been categorised as difficult ‘partners’ or environments.¹ The international community has increasingly recognised that the human cost of not engaging with countries fitting a difficult ‘profile’ is unacceptably high, and that new approaches are needed to meet the needs of poor people living in these countries. Current international strategies to address the basic quality of life of poor people, such as the Millennium Development Goals (MDGs) and Poverty Reduction Strategy Papers (PRSPs) face considerable implementation challenges in difficult environments. It is widely acknowledged that the MDGs and PRSPs are highly contingent on political decision-making by countries and donors rather than met solely through effective technical interventions. Most analyses on the best ways to achieve the MDGs generally emphasise the need for more aid, better trade, and progress on debt relief in order to meet the MDG targets² but say very little about the most effective aid instruments and channels in supporting pro-poor basic social services.

As part of DfID’s commitment to the MDGs and poverty reduction, it seeks a better understanding of the most effective ways of delivering aid for service delivery in countries where governments show little willingness or capacity to facilitate pro-poor policies and services, in respect of

- Impact on poor people i.e. measured in terms of poor people’s access to basic services;
- Building mechanisms/systems to ensure that poor people have regular and long-term access to basic services

1.2 Definitions of ‘Difficult Environments’ and Service Delivery

1.2.1 Understanding difficult environments

The consultant team for this report has used the DFID’s Poverty Reduction in Difficult Environments (PRDE) team’s definition of difficult environment:

“Difficult environments (are) those areas where the state is unable or unwilling to harness domestic and international resources for poverty reduction. Such areas typically have all or several of the following characteristics: weak governance, fragile political and economic institutions, conflict, poor economic management or are suffering the effects of a chronic humanitarian crisis. .”³

The consultant team also mapped various countries on to the PRDE team’s ‘willingness and capacity’ matrix (see Box 1). As can be seen in the case studies, the willingness and capacity framework is too static to give an accurate picture of what happens within countries at different points in time. Also the same country can fit into different parts of the matrix depending on the situation in different regions of the country.

¹ World Bank 2002, p. 10

² GUF 2003

³ Berry et al (2004) p. 8

Box 1: Willingness/capacity matrix adapted from DFID's original proposition⁴

<p><i>Will and no capacity</i> State not internationally recognised (Somaliland)</p> <p>Authority is vested temporarily in a transitional authority in a 'post-conflict' situation</p> <p>Post-conflict situation in which authority is vested in elected central government</p> <p>Central authority unable to assure equitable resource allocations to all population groups</p> <p>Occupied (by external military forces) or disputed states, with limited authority</p>	<p><i>Will and capacity</i></p>
<p><i>No will and no capacity</i> Country is conflict affected, lacking an effective central authority</p> <p>Highly dysfunctional governance structures</p> <p>Government is under international sanction</p>	<p><i>No will and capacity</i> State has partial territorial control / conflict between recognised authority and insurgent groups (e.g. Sri Lanka; Indonesia)</p> <p>Governments with poor human rights records, with repressive or isolationist governments</p> <p>Government is under international sanction</p> <p>Central authority unwilling to assure equitable resource allocations to all population groups</p>

1.2.2 Understanding service delivery

The definition of service delivery being used as the working definition for this literature review, adapted from the DFID PRDE team is⁵:

Service Delivery is conceptualised as the relationship between policy makers, service providers, and poor people. It encompasses services and their supporting systems that are typically regarded as a state responsibility. These include social services (primary education and basic health services), infrastructure (water and sanitation, roads and bridges) and services that promote personal security (justice, police). Pro-poor service delivery refers to interventions that maximise the access and participation of the poor by strengthening the relationships between policy makers, providers, and service users.

Pro-poor service delivery rests on the principles of:

- Universal access and coverage on the basis of rights;
- Commitment to equity;
- Community participation in defining and delivering services.⁶

Analysis for the case studies focuses on the degree to which the state, as either funder, provider or regulator, ensures that the most vulnerable people in society have access to, use of and has control over the basic services they need to underpin other quality of life factors. This analysis is done through the lens of different aid actors and instruments, and the ways that these influence service delivery mechanisms. For example, the Angola case study considers the work of NGOs, bilateral and multi-lateral organisations, their use of different aid instruments and their influence on health service delivery for poor people.

It is worth noting that much of the thinking around difficult environments mirrors work that has been done by DFID's Drivers of Change project. Lessons drawn from 'Drivers of

⁴ Berry et al (2004)

⁵ *ibid* pg. 8

⁶ adapted from WHO (2003) paper on "Health systems: principled integrated care"

Change' are applicable to developing appropriate approaches to service delivery in difficult environments.

1.3 Problems for delivery of pro-poor basic services in difficult environments

The OECD/WHO report on Poverty and Health⁷ highlights the need for different forms of development cooperation in countries with limited commitment to pro-poor policy or with limited capacity. As public health, education, water systems and infrastructure have largely deteriorated for a variety of reasons, provision of these services is increasingly delivered either by INGOs or through the commercial and informal private sector. There have been several consequences to shifting in this direction:

- Service delivery is **severely fragmented**, with vertical control programmes frequently delivered by parallel services established by external relief or development agencies⁸.
- **Unsustainable operational standards and facilities** are commonly put in place. Institutional, technical, and management capacity is frequently poor in countries that have endured long periods of political destabilisation or oppression. Information systems are seldom available for adequate needs assessment or service planning.
- Humanitarian agencies often **fail to adequately support indigenous capacity** during either the emergency or rehabilitation periods thus increasing the risk of little being left behind when they withdraw.
- **Local staff are targeted by oppressive regimes** when working in humanitarian or development projects. Development agencies have found the challenges of working to support 'home-grown' talent in oppressive regimes hard to countenance, as counterparts are arrested or killed.⁹
- **Lines of accountability to beneficiaries or service users are poor**, and if the state is seen not to be involved at all, then accountability of the government to its citizens is ruptured.

The above problems are characteristic of how basic services look in difficult environment countries. If the primary role of the state is to "exercise power to achieve public goods"¹⁰, including safety and security, public institutions, economic management and basic social services, then the last 20 years have seen a steady erosion of these powers in many countries. In the past few years the donor community has begun to acknowledge it's role in making this situation worse.¹¹ Macro-economic policies of the 1980s and 1990s weakened the ability of many states to provide services and security for their citizens. Accountability for government action moved from resting in the domain of the citizen to accountability to donors and the International Finance Institutions (IFIs). As Batley states: "The deep involvement of international leaders or donors in the policy making of countries in crisis can lead to the ventriloquizing of policy through national political leaders".¹²

There is at last greater acceptance that basic service delivery is not a politically neutral area, especially in weak or oppressive states. There are calls for aid to be underpinned by more in-depth country analysis that maps power relationships that affect access to and use of basic services.¹³ The challenge now is to help facilitate the space within countries for re-establishing locally appropriate forms of social contract between governments and their citizens, with one key area being the re-building of service delivery mechanisms. In this

⁷ OECD 2003

⁸ WHO 1998

⁹ Lent T (1996) describes the intimidation and violence suffered by project partners in Guatemala

¹⁰ Rotberg (2004) in Torres and Anderson (2004)

¹¹ WDR (2004); see Batley (2004) for an analysis of the 'behind the scenes' role of donors and the impact on citizen-state links. This is further reinforced by Randel et al (2002) in their political analysis of aid in the preface to "Reality of Aid".

¹² Batley (2004) pg.54

¹³ *ibid*; Jackson (2000); Schuftan et al (2003)

analysis the state is understood to have a key role to play in ensuring that fragmentation is reduced, standards are understood and adhered to and that professional capacity is available to meet service needs.

1.4 Why does service delivery in difficult environments matter?

There are several reasons given for this renewed interest in poor performing countries, including:^{14 15 16}

- Difficult environments are not on track to meet the MDGs
- Poor governance mechanisms inhibit poverty reduction and pro-poor service delivery
- Difficult environments generate adverse externalities regionally and globally (such increased potential for conflict or supporting organised crime);
- Ethical and humanitarian reasons require continued engagement
- Difficult partners inhibit the exchange and growth of global public goods such as eliminating infectious diseases, improving the environment and enhancing trade opportunities.

As with understanding the reasons to engage with difficult partners, there are a number of reasons to focus on service delivery that is pro-poor in nature:

- If the aid community doesn't provide assistance to service delivery in difficult environments the Millennium Development Goals (MDGs) won't be achieved;
- There is a humanitarian imperative to intervene where people's access to basic services has been reduced, or indeed withdrawn;
- Service delivery may offer an entry point for triggering longer term pro-poor social and political change;
- Service delivery may help to prevent some states from sliding into, or back into, civil conflict.¹⁷

These are all compelling reasons to attempt to engage with difficult development partners and to find approaches that work towards ensuring poor people living under difficult regimes can benefit from good quality, accountable and sustainable basic services.

1.5 Methodology and Scope

1.5.1 Purpose

DFID's Poverty Reduction in Difficult Environments team commissioned the DFID Health System Resource Centre to undertake a series of case studies exploring approaches to delivering services in states that could be considered difficult partners.

The objectives of the work were to understand which approaches to supporting service delivery (and under what conditions) are the most effective with respect to both:

- Their impact on vulnerable people, including community mobilisation, social inclusion and depth and coverage of services;
- Their impact on state accountability for pro-poor service delivery and longer- term institutional development.

1.5.2 Methodology

The consultant team for this project undertook project document reviews, held a round table workshop and developed case studies as preparation for this report. The scope of the project has been necessarily restricted by limitations of time and gaps and biases in

¹⁴ OECD/DAC (2001), World Bank (2002), CIDA (2003), DFID (2004)

¹⁵ World Bank (2002)

¹⁶ DFID 2003

¹⁷ *ibid*; OECD/DAC (2001)

published and unpublished literature. The concept of 'difficult environment' is newly emerging, hence the review has drawn on more accepted terminology such as conflict-affected, post-conflict, fragile and weak, collapsed or failed states.

Project Document Reviews

Project documents were retrieved from searches on Google and within individual agency websites. We also contacted key informants for unpublished reports to which they had access.

Round Table Workshop

The purpose of the round table workshop was to bring together members of the consultancy team, DFID PRDE team members and experts in the field to help identify the main issues that the team should be considering during this work. They were also asked to consider reports or programmes that they were aware of that would be useful for the team to include as part of their initial scoping and analysis.

Case Studies

Various consultants with long standing experience of working in a variety of difficult environments, drawn from a variety of institutions were asked to prepare a country case study reviewing the changes in aid instruments and channels used to deliver services to the population. The case studies map how services have been funded and supported over time within the case study countries, and then analyse the degree to which different approaches both had an impact on services for poor people as well as contributed to building state effectiveness and accountability.

Analysis

Firstly, a thematic analysis of the case studies was undertaken to identify key topics and lessons learned. Subsequently, the case studies and the wider literature examined were considered against a framework of 'willingness' and 'capacity' of states to implement pro-poor policies. Assessments of interventions and lessons learned were extracted to identify areas of good practice in enhancing accountability and/or improving pro-poor service delivery.

Limitations and Constraints

Little meta-analysis has been done of many of the aid instruments explored in the project literature. Some of the instruments and approaches used by donors are relatively new and untested. Therefore much of the literature focuses on the process of how instruments work, rather than on their effectiveness.

An effort was made to find analysis from developing country academics and activists, but this proved very difficult. A general caveat to the findings in this document is that very little published research appears to analyse the subtle relationships between political environment and service delivery, beyond a general analysis that good governance and participation provide an enabling environment. No analysis of 'what works' and why within a given environment was found.

2 EXPLORING THE EVIDENCE – WHAT STRATEGIES WORK TO ENSURE PRO-POOR SERVICE DELIVERY IN DIFFICULT ENVIRONMENTS?

This section sets out to explore the evidence of what works within the typology of willingness/capacity developed earlier. An initial caveat needs to be made here: that while experience of working in difficult environment has grown significantly, given the numbers of countries that have emerged from conflict and poor governance in the last decade, little has been publicly documented, making it difficult to learn lessons, avoid mistakes, and enhance the policy response. While grey literature abounds, and the numbers of published journal articles evaluating specific aspects of an ongoing programme are growing, there are few meta-analyses of this critical policy arena. Service delivery, in particular, is under-examined. Because of the overwhelming importance of political reconstruction, the bulk of research and analyses of the post-conflict/difficult transitional period have generally focused on this area. It is hoped that gaps in our knowledge and understanding of how best to effectively support countries in re-establishing service delivery during the difficult transition from political unwillingness to willingness will attract renewed interest.

2.1 Delivering services in low willingness environments

States with low willingness and low capacity: In these contexts the state is unresponsive to the needs of certain groups (or indeed the entire population) as well as lacking in capacity for policy development and implementation. The country may have just emerged from conflict, or still be engaged in conflict in certain parts of its territory, so that it has little control over those areas. In this situation, many donors and other development partners may treat the situation as a humanitarian crisis, resorting to direct service delivery and by-pass state-run services completely, while also setting parallel policy processes. Aid assistance is delivered through projects, with increasing efforts to develop the demand side by using community mobilisation approaches. This case study from Southern Sudan provides an example here.

Education in Southern Sudan¹⁸

With the protracted conflict in S. Sudan, and the historical artefact of the region being neglected, there is no state structure providing service delivery in most of S. Sudan except in the garrison towns. Basic service delivery for several years was provided directly by international NGOs, loosely coordinated through Operation Lifeline Sudan and with little guidance from the Sudan People's Liberation Movement (SPLM) or the Sudan Relief and Rehabilitation Association (SRRRA). Security, health and food security have dominated the humanitarian agenda for the last 20 years in S. Sudan, with very little attention given to education. In the early days of the civil war, education work was in fact manipulated by the SPLA, as they saw the young people attracted to schools as captive recruits into their army.

More recently, with the prospect of peace increasing in Sudan, there has been more interest in filling the strategic/policy vacuum that has existed from government, both north, and now the nascent southern government. This strategic planning capacity, and the technical capacity (in terms of curriculum development, teacher training and teaching) are sorely lacking at official levels, and will do so for some time to come. Where roles are beginning to be filled at local level, there are serious problems with primarily, if not only, men being recruited into various positions.

The focus of attention is now on developing formal education systems, with organisations such as Save the Children UK taking a lead on advocating for primary education. There is an acknowledged gap in the provision of basic education, that is, providing adult literacy and numeracy skills to support skills-building in young people and adults who are no longer of primary school age. One innovative project that has worked with communities during the conflict and now as the region moves towards peace is Education for Development's work in one part of South Sudan. This programme focused on

¹⁸ Newell-Jones (2004)

local capacity building and peace building as the underlying approach to developing literacy skills. Communities were involved in developing the curriculum for the training themselves, allowing them to conceive of taking a wider role in decision making more generally. EdDev has worked through a local NGO throughout its operations in South Sudan ensuring sustainability and the development of appropriate services.

Lessons learned:

- **working through community groups does empower members to be more demanding about access to different services, e.g. gives them greater voice**
- **being explicit about the inclusion of women as project staff, teachers and beneficiaries is vital to ensuring gender equity in community interventions;**
- **local organisations can be hostile to greater inclusion of women, and so sensitive handling and advocacy is important, and can be achieved through external input.**

An acknowledged limitation to the work of this project was that it didn't feed into wider discussions of education policy development taking place in S. Sudan. "There was local of involvement in policy development in the wider context, which probably had a two-way impact. Policy development did not take into account the experiences from these (and other) projects and projects were sometimes slow to react to inevitable change. . . Attempts are being made to develop closer networks in the context of Sudan and this appears to be resulting in the expertise developed on a minor scale at a very local level being utilised in the wider sphere."¹⁹

In other cases development partners have sought out local partners, be they local government or NGOs, with whom services can be developed and at least monitored within some larger framework. Here, donors develop parallel policy systems, but still may aim to support public service delivery, where viable. The following example from DRC illustrates how this can be done.

Health Service Delivery in the DRC²⁰

The Democratic Republic of Congo is emerging after several decades of upheaval, first created by the kleptocracy of Mobuto and then civil war. Health service delivery has a long history of international involvement, beginning in the 1970s when international organisations such as Oxfam provided technical assistance to the Ministry of Health and decentralised management structures were set up, creating regional medical inspectorates and *zones de santé*. Different donors and implementing partners took responsibility for providing health services to different parts of the country, using the state structure as its basis. Over the years providers have taken on clinics and delivered health services themselves, by-passing local systems entirely (mission clinics and private clinics); or they have worked to support notional government health staff. The government (of then Zaire) provided no funding to the health system, despite the vast natural resource wealth of the state, and large funds transiting national accounts. All donor funding went directly to NGO partners providing the management and services.

The European Commission has been supporting similar work in the DRC since 1994, with a policy of 'no enlargement and no regression'.²¹ In other words, the objective of the programmes supporting health services is to try and maintain the existing structure and keep health staff in place, so that no further deterioration occurs. A change from previous renditions of the same type of support in the health sector, has been involving the government increasingly, at national and regional levels, in taking on standard setting and regulating health services. In the latest phase of EC funded programmes, Memorandum of Understanding have been set up so that a more formal contractual relationship has been developed between the government and the NGO providers. As the EC

¹⁹ Newell-Jones K (2004) "A Review of small scale educational interventions on Literacy and Conflict Resolution/Peace-building in Guinea, Sierra Leone and South Sudan".

²⁰ De Lamalle (2004) Review of the EU Intervention in the health sector in DRC from 1994.

²¹ *ibid*

programme only covers a certain number of regions, it is unclear what arrangements other donors have put in place to support similar structures.

Lessons learned in this work have included:

- **The need to bring state actors into the equation, at some level, whether national, regional or local, in order to develop government capacity to provide policy and regulatory frameworks;**
- **The provision of support, both in terms of technical assistance and training as well as material and equipment resources has allowed public health services to 'hold the line' of where they were prior to the EC funding beginning.**
- **Differences in contracted providers has led to very unequal results in service provision – and a number of people now suggest that it is important to separate projects supporting institutions from clinical service delivery, as they require different competencies;**
- **Sustainability of the current system remains problematic. Zaire/DRC was one of the first countries to introduce cost recovery through a Bamako Initiative type programme, in the 1980s. At the time many NGOs involved in service delivery considered this an ill-advised approach to cost-recovery, as the country was experiencing hyper-inflation, resulting in an utter inability to keep up with the cost of drug purchases. There was also a feeling that with some of the fees raised through cost recovery returning into a government system that provided no support to health services, that this was merely another form of revenue generation that would never benefit the people. Cost recovery remains a principle within health programming in the DRC, although no assessment of how this effects poor people's access has been undertaken.**

Project evaluations seem to indicate that in areas where health services were running to some degree, the PATS approach has helped to stabilise them and ensure there is no further degradation. In areas where attempts were made to re-introduce health services that had disappeared, the project was less successful. It is unclear whether this is because of the choice of NGO implementer in these areas or what other factors may have caused problems. It is also unclear to what extent other donors are following the same policy and harmonising under a contracting-in system within DRC, nor what type of support was given to the Ministry of Health, except in terms of helping to formalise the relationship between the ministry and its' contracted partners.

A final example of low willingness/low capacity comes from Angola, which poses another set of dilemmas for development partners. The government does not appear to be interested in pro-poor service delivery, or even development of basic services in general. Like the DRC, Angola has a vast natural resource base that could in theory fund much of the country's development. As the last peace agreement is holding and warring factions have been successfully integrated into the new government, Angola has even less reason not to invest in basic services for its population, but so far has found this difficult. Lack of transparency in how government uses resources, corruption and governance are all key issues for donor relations in Angola. Donor mechanisms for support have included direct project support, strengthening civil society and lower levels of government (provincial and municipal levels).

HEALTH SERVICE DELIVERY IN ANGOLA²²

During much of the 20 years of Angola's civil war, health service delivery was provided primarily through government run services in government-controlled areas, with support from Cuban medical staff. Due to insecurity in the country the rural health network went into rapid decline, while most health investment went towards tertiary health care. With the end of the Cold War, the return of most Cuban personnel to Cuba and an increased willingness of donors to engage with the Angolan government, a more varied model of delivery developed that included INGO providers. Support for reconstruction of government infrastructure and institutions was channelled through mainly the UN and INGOs. There appeared to be a minimum commitment to health and the provision of health services in general by government. As a result, and despite donor efforts at institutional strengthening at central MOH level, as well as provincial and municipality level, projects had limited impact as there was little strategic direction and little outreach to communities.

With the return to hostilities in 1998 many donors withdrew from Angola, though continued to fund INGO programmes there. SCUK decided to continue with its programme of building capacity at the provincial level, rather than intervene directly itself. This same tactic was followed by other INGOs in other provinces, with one objective being that if provincial health ministries were strong enough they could make demands on the central level. However, as INGOs were providing all the support, with no direction from the central level, accountabilities were distorted, and service delivery fragmented across the country. In other areas this fragmentation was accelerated by the return of humanitarian agencies that worked in parallel to official structures, which in turn contributed to the degradation of national service provision. Throughout this period access to rural areas remained difficult, if not impossible and less than 30% of the total population had access to health care.

With the return to peace, the challenges for rebuilding both the physical infrastructure and social fibre of Angola are immense. The underinvestment in state infrastructure and human capacity over decades of conflict continues as the government remains somewhat uninterested in committing its own financial resources. Current health programmes, funded by the World Bank, UN agencies and EU. The UN agencies' emphasis is currently on putting in place a Minimum Health and Nutrition Package that will get basic services out to 300,000 people in 15 provinces. The project involves training health unit managers, integrating former UNITA health workers, strengthening the health information system and disease control response. The World Bank is funding a Social Support Fund that aims to rebuild social capital, with an emphasis on community driven development.

Lessons learned

While progress is being made, many similar problems are emerging now in Angola, which have been seen in other situations:

- **Poor capacity of state services is not being adequately addressed, either through provision of services by NGOs or other alternatives;**
- **Donors and INGOs concentrate on specific sectors or geographic areas, with vertical, non-integrated approaches. This continues the dynamic of fragmentation.**
- **Poor engagement from central government and with civil society has created a disconnect in service provision, with much work occurring in a policy vacuum.**

2.2 States with low willingness and some capacity

Very few states fall under the rubric of low willingness/high capacity, but there are a number that could be classified as having 'some' capacity. As with other low willingness environments, working with lower levels of government (at state and district level) as well as with community organisations comprise the main strategies.

Within this category we reviewed education in Nigeria, a country with a complex Federal structure and rich human resource base, though this is highly varied across states. Previously DFID funded projects only at local government level and through civil society

²² Fustukian S (2004) Angola Case Study. London: HSRC

organisations in an effort to by-pass a Federal regime that was highly corrupt and abusive of human rights.

EDUCATION PROVISION IN NIGERIA²³

Nigeria provides a good example of a country that has maintained some degree of stability with conflict erupting in some states over the last 40 years. Education policy is determined by the Federal government, with implementation the responsibility of the states. The States willingness to support education appears to be variable, being dependent on the Education Commissioner for each respective state. Much greater willingness is evident at local government level and amongst traditional leaders. Capacity for strategic planning and policy development appear relatively low, and now willingness to ensure adequate salaries for teachers has impacted on their motivation to remain in the education sector. Furthermore, there is a real problem with a significant gender imbalance amongst teachers and managers.

The actual implementation of education provision is complex. The Federal government must approve all inputs into education, while States have to agree to implement the project being offered, or request to be included for funding. In a number of states where education provision has been particularly variable, Nigerian CBOs have set up their own schools (e.g. in Kaduna, women's groups have been very active in providing primary education for girls). The World Bank has provided a loan to the Federal government to support its programme of Universal Basic Education, with the focus on this programme on the educationally disadvantaged. Unfortunately the selection of the local government areas to benefit from increased funding for UBE has been politically determined rather than based on poverty or disadvantage. More success has been noted in smaller scale programmes that have worked directly with CSOs in developing locally relevant education services. Other education projects attempt to take a multi-sectoral, multi-level approach (e.g. DFID funded UNICEF project). This ambitious project attempts to decrease the gender gap in education access in Northern States, using a broad community development and cross-sectoral approach. In effect, the project tries to combine elements of previously successful projects, building on using local government and CBOs as entry points, while also attempting to get Federal and State buy-in at a policy level. Time will tell if this approach is successful:

Lessons learned:

- **Experiences are showing that mobilisation of significant and diverse sections of civil society can be readily achieved through appropriate interventions; provision of counterpart resources is a considerable catalyst for this purpose;**
- **'Critical mass' is an important element of success in creating sustainable outcomes for other projects (e.g. having enough activity in a focused geographical area);**
- **Federal government involvement appears to be a necessary bureaucratic level to include, rather than a driver of significant policy or standards. Funding of education service provision may be contributing to this as each State or locality responds to the demands/philosophy of individual funders and civil society organisations. Poor coherency may be a result of this approach to working in Nigeria.**

What hasn't been studied here is the extent to which DFID and other donor strategies that worked with lower levels of government and CSO's helped to contribute to current capacity within these organisations to take on more of a role in education provision. This is an area that would be good to evaluate more rigorously, in order to see whether the evidence fits the rhetoric.

While acknowledging that the evidence base around the links between CSO capacity building and future capacity for scaling up is weak, there are projects/programmes that have been evaluated and show that long term project assistance does make a difference. One such project was implemented in Mauritania and has undergone a number of evaluations of its different phases over the 15+ years that it ran.

²³ Sibbons M. (2004) Nigeria time-seried analysis of education services.

INTEGRATED RURAL DEVELOPMENT IN MAURITANIA²⁴

Mauritanian society is rife with ethnic division, with the key split being between 'white' moors, who have political power and 'black' moors, who were often former slaves of white moors. During the Sahelian drought of the mid-1980s, Oxfam provided assistance to a remote black moor area in eastern Mauritania, Affole region, using standard emergency relief mechanisms. Rather than leaving the area when the crisis phase was over, Oxfam staff decided, in order to prevent ongoing crises in what was an extremely vulnerable population, that they would provide rehabilitation assistance. The ensuing project grew out of the experience of the relief phase, which in itself had worked closely with affected communities to develop appropriate relief interventions. This allowed for an easy transfer to rehabilitation work, which focused on the communities' top priorities: water and income generation.

As there was almost no capacity in the project area when Oxfam began its work there, and because the government showed no interest in supporting development for this particular population, Oxfam managers made the unusual decision to continue direct service delivery in the area for a period lasting 15 years. During that time project management moved from European-led to having a manager from a similar ethnic group, though of Malian nationality. Project staff were developed from the local area and by the end of the project it was agreed that work would continue by helping local communities and project staff form their own CSO.

Lessons learned:

- **In very difficult environments, a very long term commitment is necessary to help communities develop strategies for sustainability;**
- **Flexibility in Oxfam's funding meant that developmental approaches could be employed from early stages of the relief phase;**
- **Building capacity of local communities is fundamental to ensuring long term sustainability of project interventions. Focusing on women's literacy and income generating skills in particular provided greater stability in the community and more revenue to be invested in local activities.**
- **It takes time and energy to work towards building a local CSO in highly marginalized communities.**

It should be noted that the Mauritania project only had guaranteed funding for 3 to 5 year periods, so that while project staff had some security by being underwritten by Oxfam's own funding, they also had to go through a number of periods of insecurity before knowing that funding applications had been accepted. This in turn meant project activities had to adjust to new funding and donor requirements, rather than being allowed to evolve more organically over time. The EC ended up being a major donor to this project, as was the Spanish government through Oxfam Espana.

Another important lacunae to the approach taken in the Affole project was the fact that no real link was made with national government or trying to change the government's neglect of its most marginalized population groups. In fact, during the course of the project period Mauritania expelled a number of Mauritanian citizens to Senegal, claiming they were all immigrants, sparking off a brief war between the two countries. Those expelled were all from black ethnic groups whose families inhabited both sides of the border for centuries. The donor community has done little to tackle the very divisive ethnic policies of Mauritania, and hence projects like the one in Affole, while useful to one particular area, do not contribute to any greater move to pro-poor policy.

2.3 States with partial willingness and low capacity

As the only states in the category that are of interest to development partners are those that show partial willingness to employ pro-poor policies and provide services, but who don't have the capacity, this study draws on examples from these states

²⁴ Oxfam (various) Affole project documents

Many states with whom DFID has developed strong relations fall into this category. They have signed up to PRSPs and may even have initiated poverty reductions strategies well before the advent of PRSPs. However there remains the question of how the limited resources available to these states is used. An example of this is Uganda, which has led much of the pro-poor agenda and has benefited from debt relief as a result. There still remains much to be done, as a long term conflict continues to rage in the northern districts of Uganda.

HEALTH SERVICE DELIVERY IN UGANDA²⁵

Uganda has had almost 20 years of reasonably stable government. The National Resistance Movement took over a country devastated by war in 1986, where infrastructure had been all but destroyed and human capacity severely reduced. Since coming to power the government has implemented a programme of national reconstruction and reconciliation, all with varied effect. During the early years of the NRM, a large amount of technical assistance was provided the government by multi-lateral and bi-laterals, in order to make up for reduced local capacity. While the World Bank and British Government provided much needed support to the Ministries of Finance and Planning (now one ministry), UNICEF 'adopted' the Ministry of Health, and came to be seen as the 'alternative' MOH. Strong leadership with a clear focus on pro-poor strategies became ingrained in MOH and local government thinking through close collaboration with UNICEF and other donors.

Conflict has continued intermittently since the NRM came to power, affecting primarily the north of Uganda where the pre-NRM leadership came from. While government policy nationally is pro-poor, and Uganda has been well in advance of many other low income countries in developing pro-poor strategies, these policies have very little reach into northern districts, both for political and security reasons.

Health service delivery in most of the country works through a decentralised system of health care, managed by districts. A comprehensive package of care, from primary level through secondary level, is offered in districts, and the government has shifted budget allocation away from supporting the main tertiary hospital in Kampala to supporting primary care in districts. Much of health funding is now channelled through a SWAP or direct budget support, though some major donors (USAID, GTZ) continue to provide project support.

National health spending in northern Uganda is less per capital than elsewhere in the country. Health service delivery is heavily reliant on INGOs and faith-based organisations (the main functioning hospital in Gulu is a Catholic mission hospital). A main finding from the literature is that the government has failed to acknowledge the special situation and needs of communities living in conflict in Northern districts. Instead a policy of business as usual is pursued, so that service interventions in northern districts have tended towards being more fragmented rather than guided by conducive policy.

Lessons learned over the last 20 years include:

- **The need for strong leadership, both from the external donor community and from government to support equitable reconstruction and pro-poor strategies;**
- **The need to provide appropriate, long term TA first to replace and then to develop capacity from within government and public services;**
- **The value of providing support to local government services to maintain staff in their posts, with a view to having sufficient capacity for the post-conflict period.**
- **The importance of targeted support to the most vulnerable groups within the population affected by conflict. In the case of Northern Uganda this includes children and women subjected to sexual violence.**

Uganda could potentially pose quite a dilemma for donors. Its evolution from country in dire crisis to stable country benefiting from direct budget support and debt relief has been

²⁵ Carlson C. (2004) Review of health service delivery in Uganda – general country experience and Northern Uganda.

remarkably rapid. While lessons learned above begin to point the way for why this has been able to occur, there again is now clear research evidence about whether there was some 'magic mix' of national leadership and donor leadership in the late 1980s that got it just right. What is known is that tremendous effort did go into rebuilding government infrastructure and human capacity, reasonably quickly (donors were initially hesitant just after the NRM took power), and that this has reaped benefits in terms of pro-poor policies. However, could donors have done more to persuade the government to put more resources and effort into Northern Uganda earlier on, in order to prevent the problems the northern districts face today? And could more be done now?

Another country that has just emerged from conflict, and which has been relatively successful in instituting pro-poor strategies for parts of the country, is Sri Lanka. The following case study looks at how education provision has been extended to the northern province in this post-conflict era, and the challenges integrating the northern province into national systems.

EDUCATION IN SRI LANKA²⁶

While the government of Sri Lanka is very willing to support 'education for all' its history indicates that it is adept at manipulating state institutions to represent the Sinhalese majority, to the detriment of minority groups. The roots of conflict in Sri Lanka can be linked to this systematic manipulation in the first years of independence. The North and East Province (NEP), where the population is majority Tamil, has been systematically excluded from service delivery, first because of putting resources towards the Sinhalese majority, then because of conflict and now because of institutional/historical reasons.

The NEP remains outside the mainstream of national policy and planning. NEP education plans are not considered within the overall education national plan, except in a limited, and special case, fashion. As a result, the NEP has suffered a severe lack of teachers in newly re-opened schools and has missed out on other potential efforts to redress historical imbalances.

NGOs and GTZ working in NEP throughout the conflict period and into this post-conflict period. These programmes have undertaken conflict analysis and have ensured that acknowledging the psycho-social impact of conflict on children, and have included training for teachers in these issues. National government has not been able to influence the coordination of different actors in NEP and lack of coordination did lead to some frustration and possible duplication. Education delivery in refugee camps tried to follow the same curriculum as for government schools, so that education for displaced children would not be too disrupted.

Lessons learned:

- **Due to the logistical demands of working in the NEP it was clear that, at least for the time being, the government needed project support to delivery programmes.**
- **Having a social development advisor or someone similar on the team, ensures that issues of conflict analysis and exclusion have a bearing on project development and implementation;**
- **Ensuring that project teams were inclusive of all parts of the population helped ensure greater readiness to support post-conflict eras;**
- **Sound, thorough and participatory analysis, information based policy development, formative monitoring and evaluation systems representing all interests, along with adequate budgeting, are key to successful service delivery**
- **The inclusion of external and objective critical friends throughout the life of programmes, along with support and influence from elder statespeople helped with providing a unified national perspective and push for an inclusive approach to education.**

As with Uganda, donors in Sri Lanka need to consider to what degree they can help with ensuring that the root causes of conflict (inequity in power and in services for northern and eastern provinces) do not continue, while also not provoking southerners to feel that there is somehow a 'reward for conflict' being given. It is important to assess what measures the

²⁶ Sibbons M. (2004) Sri Lanka Case Study. London: HSRC

Government of Sri Lanka are taking that work towards resolving the causes of conflict that donors can support institutionally, and measures may allow resentment to continue, and which need advocacy to change.

The last case study features a state, Afghanistan, that could be categorised as having high willingness at central level, but which has questionable political control and so little capacity, that the challenges of putting pro-poor policies into place seem insurmountable.

Health Care Delivery in Afghanistan²⁷

20 plus years of civil war, Soviet style concentration of health care in hospitals and variable control by various governments over much of the Afghan territory has contributed to very poor access by rural and poor communities to health services. No government during this time, nor even under the more stable monarchy that ruled Afghanistan prior to the Soviet invasion, gave much attention to wide spread access to health care across all communities.

While the loose association of Mujahadeen ruled in Afghanistan there was no central direction to health policy, and communities were entirely reliant on what interest their particular war lord had in their well being. During this period numerous NGOs, mostly supported with EC funding, established services in Afghanistan, mostly in those areas accessible from Pakistan. Due to the nature of this way of working, NGOs tended to establish programmes according to their own criteria and assessment of need, so ranged from direct service delivery to the setting up of local NGOs to delivery services themselves. The UN played a limited role.

During the Taliban period there was some space for NGOs to carry on their work, both in Mujahadeen controlled and Northern Alliance controlled areas. The UN began to play a more enhanced role and attempts were made to coordinate to provide an overarching health strategy. INGOs and the UN continued to work to develop local NGOs to assist with health service delivery.

Current government policy is more conducive to rapid improvements in health service delivery. In recognition of the very low capacity available within Afghanistan, the government has opted to contract in external agencies to provide services, on the basis of a Performance-based Partner Agreements (PPAs). This allows central government to provide an umbrella role in determining policy direction, regulation, standardisation and monitoring of health service delivery, while not having to also support the actual delivery process itself. Former staff of local NGOs now work with government, in particular in the unit supporting PPAs.

Lessons learned:

- **A pre-requisite for actors to implement service delivery strategies in such a way as to enhance achievement of MDGs is to have some body providing overarching policy and strategy. This could potentially be the WHO, though it hasn't shown any inclination to do this so far;**
- **Capacity building within humanitarian interventions (e.g. training local health staff to work in clinics, or using existing local health staff to keep their skills updated) may provide the foundations for future service delivery in the post-conflict era, especially if it is agreed that non-state providers would have a role in ongoing service provision after the humanitarian phase is completed.**
- **Service delivery in environments such as Afghanistan is going to be very costly and this cost cannot reasonably be expected to be borne by the government or the population;**
- **The model used in Afghanistan (which is similar to the PATs model in Congo) may have far reaching consequences, both in terms of human health resources, as well as for government engagement and health impact. These effects are not fully understood and will need review.**
- **One corollary of understanding the effects of Afghanistan model is assessing how the needs of the most hard to reach groups are being met. The Afghan case study indicates that the marginal costs of reaching the most isolated communities may be too high and that services for isolated areas may be left out of contract agreements.**

²⁷ Sondorp E. (2004) A time-series example from Afghanistan – 1978 – 2004. London: HSRC

More willing governments do make it easier for donors and other partners to engage more directly at a policy level and to introduce more innovative aid mechanisms that support greater government ownership of policy and programmes. Contracting in/out is a good example of how to engage with government and support government coordination, while also allowing more alternatives to service delivery than just supporting services through the public system. Where much of this started, in Cambodia, evaluation of this approach indicates that there would appear to have been significant increases in service use and decreases in family health expenditure, there were also problems with government ownership below national level.

Cambodia Health Care Contracting

A number of successes and failures have been reported in one of the districts in Cambodia where the NGO HealthNet International applied the contracting in model²⁸. Despite increased official user fees, utilisation of services was increased. There was a decrease in total family health expenditure, from US\$18 to US\$11 per capita per year. This therefore contributed significantly to poverty alleviation, as the district was one of the poorest in the country and health expenditure one of the main risks of economically 'dropping out' for Cambodian families. Health was the primary reason for families to lose their land, which is the first step in a vicious cycle of poverty.

The World Bank²⁹ maintains that findings included: annual per capita recurrent spending by government and donors higher in contracted-out districts; all districts improved service coverage in a short time; contracted-out districts often outperformed contracted-in districts. But maternity deliveries assisted changed by only small amount in all 3 districts, and there were no differences in increase of vitamin A coverage, and the level of immunization also remained modest. Out of pocket expenditures on health services fell dramatically in contracted-out districts but increased slightly in contracted-in and control districts. This latter finding conflicts with the findings above about contracting in³⁰ state from their experience about contracting-in in their district (see above).

Lessons learned from Cambodia include:

- **Among other things, that while the decrease in total family health expenditure of some 40 % is impressive. 'many questions remain, and further pilots will have to be undertaken to establish the feasibility of the system at higher management levels as well as the sustainability of the system at district level'³¹.**
- **For sustainability future contracts could gradually be awarded to Cambodian companies instead of international NGOs, possibly first in a consortium with external organisations.**
- **A number of problems were faced in state accountability and governance. For example, contract management was initially not fully understood and accepted by government health staff. Contracting services to NGOs was seen as a threat to MoH staff. Provincial health authorities became the main opponents of the contracting approach as it took away power and they did not directly benefit from the contracting process. However, experience was gained at central level MoH where a project coordination unit was established in the ministry, the contracting agency.**

There would appear to be room for much more exploration of this model, especially as it is being employed in more and more places. At the moment, observers suggest that there are still a number of unknowns about the overall impact of the contracting approach, and yet it is being increasingly replicated.³²

²⁸ Soeters and Griffiths 2003

²⁹ World Bank 2003

³⁰ *op cit*

³¹ *ibid*

³² Sondorp (2004) personal communication

3 LESSONS LEARNED

The six countries explored through case studies for this report are each unique in why they are considered difficult environments and in the historical processes that have brought them to where they are today. Uganda and Sri Lanka are not seen as difficult development partners from a number of perspectives (both have active PRSPs, are committed to meeting MDG targets and long term pro-poor policies). However both countries have regions that have been or continue to be, outside government control, where the local communities consider themselves deliberately disadvantaged by the state and where the national political leadership is ambiguous about resolving many of the problems facing these regions. Democratic Republic of Congo and Angola have both recently emerged from protracted nationwide conflict, have immense natural resource wealth (which has been a significant cause of the conflicts) and are beset with institutionalised corruption at most levels. Afghanistan has also been a country in turmoil for over two decades, compounded by a period of time under an extremely repressive regime. Unlike DRC or Angola, Afghanistan does not benefit from enormous natural resource wealth, limiting further the government's capacity to improve quickly the well being and living standards of poor Afghans, even if given a stable, peaceful environment to work within.

In analysing the case studies done for this project one key finding emerges. **All different types of aid instruments used can have a positive impact on poor people and enhance state accountability/effectiveness. The critical difference between programmes that achieve impact and facilitate accountability, and those that don't lies more in the strategies and processes employed for planning, implementing and monitoring the work being done.** From the findings in the case studies, it is therefore less important to focus on what funding mechanism or development partner is used, but rather on whether the following strategies are used at policy and operational levels:

3.1 Policy and strategy level

Leadership and coordination: Successful interventions (in terms of impact and accountability) were those where good local level interventions can be translated to national policy level, or where there is a national driver from the outset. For example, in Afghanistan, the World Bank took a lead role in providing the vision and drive for developing a system of contracting health care. The EU has played a similar role in the DRC, sharing the technical coordination role with WHO. In Uganda and Sri Lanka, national policies have helped to inform district level coordination of services, and donor efforts have concentrated on reinforcing district/provincial coordination. Therefore, there is no one agency that appears best placed to play this role. What is apparent is that coherence, relevance and coordination of external aid are critical to the reconstruction and development process. Poor coordination can reflect the tensions and ambiguities in relationships between government and donors, between government and NGOs, and between donors. The fact that there does not seem to be much leadership or coordination for health in Angola may reflect this.

Leadership and coordination can help avoid some of the pitfalls of uncoordinated service delivery response in deteriorating situations, where knowledge and skills within organisations suddenly become lost as communities are displaced and development partner staff change. The DRC case study highlights this well, whereby EU support to existing health structures helped to maintain a certain level of services despite the DRC's collapse into civil war. Similarly, the national policy frameworks provided by governments in Sri Lanka and Uganda have helped to ensure that basic institutional structures are maintained, even if circumstances make delivery of services challenging or impossible.

Identifying ways to involve state actors: It is clear that state actors need to be engaged with wherever possible, and provided with an appropriate strategic role. Though still not well evaluated, the practice in Afghanistan and DRC of creating a strategic space for state actors

to sit, in policy making, regulating and monitoring services, while non-state (and state) actors are contracted to deliver services within the agreed policy framework, seems a rational way forward in countries where human capacity is low. Even in areas where the state may have little or no territorial control, as in Uganda and Sri Lanka, the principle that the state's policies for service delivery should still be adhered to is sound, though may need considering on a case by case basis. For example, teaching refugee and displaced children from the Sri Lankan national curriculum appeared to work well, ensuring children weren't disadvantaged by their displacement. In Uganda district health policies and strategies help inform how services are delivered and managed in accessible areas. The case studies (notably Uganda and Sri Lanka) also demonstrate that special measures are needed in those regions that are entangled in crisis, and cannot operate as 'business as usual'. However the case studies also indicate the need for some sort of facilitated dialogue to take place that will allow all partners in service delivery to work towards delivering a more standard service, as this facilitates scaling up, as environments move from difficult to less-difficult.

Linking in with state structures as well can help to dispel the image of the state disregarding its responsibilities towards its citizens. Where service delivery is provided by external agencies with no connections to local structures, a further erosion of state legitimacy occurs in the eyes of its citizens.

Improving the transition from relief to development: Building the capacity of state and non-state actors should be integrated into all programmes of work in difficult environments. By including capacity building in service delivery strategies, organisations can incorporate the long term perspective even while providing short term interventions. The UN Secretary General has commented that "Relief efforts must be a step towards development, and must be delivered in ways that promote, rather than compromise, long-term development objectives."³³ The advantages of incorporating capacity building, as seen in our case studies and in the literature include:

- Empowering communities: an important lesson learned in the first Northern Uganda Reconstruction Programme (NURP) was that one reason for the failure of the programme to deliver was due to not including and working with local communities. A similar realisation in Angola's first Social Action Fund has led to the World Bank to ensure projects are community-driven in the second Social Action Fund. It is too early to assess to what degree community driven approaches have helped improve outcomes and impact;
- Ensuring continuity during unstable periods: often when violence erupts around project sites expatriate staff are evacuated to safer havens, leaving behind their local colleagues. If those colleagues have been trained up in basic skills they can continue to deliver services, which are often more needed as instability increases;
- Building the basis for scaling up: Afghan NGO staff working in health service delivery in Afghanistan now populate key posts in the new Ministry of Health.

Capacity building however, needs to be treated with the same sensitivity as other aspects featured above. Many areas that have suffered long years of neglect, due either to violent conflict or state retreat, may not have well educated and skilled individuals to take on higher level service delivery functions. As such, assistance efforts need to accept that external staff for senior positions may be necessary for a longer period of time but still incorporate a planned phasing out.

Securing the rights of the very poor: One feature of most fragile states is that there is often active discrimination against one part of the population in favour of another. This may manifest itself in abuse of basic human rights and gender-based violence where state

³³ UN Secretary General (undated) The causes of conflict and the promotion of durable peace and sustainable development in Africa. p. 14

actors, their agents or those fighting against the state abuse rights with impunity, as has been seen in Sudan, Angola and Northern Uganda. Or this may manifest itself simply as neglect of the group being discriminated against, as has been seen in Sri Lanka and Mauritania. All development partners have a responsibility under numerous UN agreements to use whatever means is at their disposal to protect the poorest and most vulnerable groups, and to bring those perpetrating abuse to account. This could be either through direct intervention with the actors committing abuse, or through supporting specialist human rights organisations to monitor and expose cases of abuse. In these cases, making sure the services exist and are available are not enough if the very poor are to benefit from them.

3.2 Operational level

Developing strategic planning and management skills: As much effort may need to be put into developing the strategic planning and management skills of state actors and local NGO staff as is taken to develop technical skills for service delivery. This area appears to be particularly neglected by assistance provided in difficult environments.

Specific programme staff should demonstrate capacity building competencies. Programme implementers may be highly experienced and competent technicians and managers, but may not have adequate competencies for capacity building. It is wrong to assume that someone who is highly competent in their field is also highly competent in training others. However, capacity building competencies are not often a key feature in project staff person specifications even if there is a training component in the project.

Ensuring a continuous funding stream: One of the major problems with taking longer term approaches to humanitarian assistance is how donors divide emergency funding from long term development funding. Short-termism is built into funding mechanisms that only provide enough to cover the first six to 12 months of a project. Many NGOs in particular complain of breaks in continuity of projects due to separations in funding. As with pro-poor budgeting and funding mechanisms in general, if the fundamental principles are to support pro-poor strategies and a long term commitment, then the proof is in how funding is allocated.

Building sustainable systems: Sustainable systems can be nurtured in difficult environments through a number of strategies, including genuine efforts to ensure community participation to creating greater capacity at local government level to working with national government to establish a more enabling policy environment for pro-poor service delivery. Where DFID should begin its intervention for building sustainable systems depends entirely on the context. In all cases, the key principle to be followed should be that local capacity already exists, whether in communities, civil society or in government, and that community members, civil society and/or government must be involved at the outset in planning, delivering and monitoring services.

Reaching the poorest: Where active or passive discrimination or abuse is carried out against particular groups living in already difficult environments then donors need to employ special measures that ensure that these groups are not excluded from receiving much needed services. Targeting of programmes (such as setting up centres for women who have been sexually abused) is the only sure means of reaching the poorest in these cases.

Harnessing non-state providers: Where governments provide pro-poor leadership they have greater capacity to coordinate activities in both the public and non-state sector. Where governments are more fragile, or show weak interest in getting services to poor people alternative coordination mechanisms need to be put in place. In many places the UN, through UNOCHA or UN bodies, provides strategic oversight and coordination of interventions by non-state providers. Donors need to work closely with the UN to ensure that coordination of service delivery efforts does take place and is effective, while also

making plans for phasing out certain aspects of this type of assistance as the political and/or security situation stabilises.

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