SERVICE PROVISION IN DIFFICULT ENVIRONMENTS:
ISSUES ARISING FROM DFID SUPPORT TO HEALTH SECTOR INTERVENTIONS IN BURMA, AFGHANISTAN AND NEPAL

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EXECUTIVE SUMMARY

This paper examines three DFID-funded health sector interventions in order to identify key issues that need to be considered when designing and implementing sectoral interventions in contexts where the international community has a ‘difficult partnership’ with the state.

A conceptual framework is presented for analysing the interventions which includes three dimensions of the problem: a) working with states that lack internal or external state legitimacy, b) designing and implementing interventions that will be sustainable, c) designing and implementing interventions that will have maximum impact on poor and vulnerable people.

This framework is then used to analyse the three examples. First, a ‘Quick Impact Project’ in Nepal that used government structures to supply medicine and supplies in Maoist held areas. Second, a capacity building project in Afghanistan that worked with staff the Ministry of Health to improve their policy development skills. Third, a joint UN programme in Burma that is working with non-governmental organisations in the area of HIV/AIDS treatment and preventions.

The paper identifies five key issues for policy makers to consider:

Politics matter: In our three examples the political landscape shapes the approach to service delivery taken. While political analysis is a key to success in all contexts, it appears to be even more critical in difficult environments.

The role of the state: The perception of the potential role of the state in the delivery of the service(s) influences both the channels and systems through which donors work. This includes the balance between centralised and decentralised structures, and the role of non-state actors (see below).

The role of non-state actors: This will vary across contexts and between sectors. In all our examples, non-state actors (NGOs, UN, private companies) play a crucial role with as service providers, or as regulators of providers.

Trade offs: Our analysis indicates that there are trade offs that need to be made between issues of state legitimacy, impact on the poor, and sustainability. Decisions as to where to place the emphasis should be clear and transparent.
1.0 Aim and objectives

This short paper focuses on DFID experiences of supporting health service interventions in difficult environments in Asia. It aims to raise issues to be considered when designing and implementing such interventions.

The paper has two objectives:

- To examine how state legitimacy, sustainability, and service delivery impact have been addressed in DFID-supported health sector interventions using examples from Afghanistan, Burma and Nepal.

- To suggest some issues for consideration when designing and implementing service delivery interventions in difficult environments.

The study was produced through reviewing available project documentation and through discussions with DFID advisers in London involved in the projects. The study examines specific interventions within DFID’s broader support to Afghanistan, Burma, and Nepal. It does not undertake to review entire programs or the broader development context and so represents only a snapshot of support to those countries.

2.0 Rationale

The Monterrey consensus established a global commitment to development partnerships based on mutual accountability and commitment to poverty reduction and growth. ‘Difficult environments’ can be defined as states where government commitment to poverty reduction and growth is weak. In these countries, the international development community has difficulty engaging in country-led development partnerships such as the Poverty Reduction Strategy (PRS) process or the Comprehensive Development Framework (CDF). The DFID’s Poverty Reduction in Difficult Environments (PRDE) team has been developing its approach to this problem. Difficult environments may arise for a number of reasons, including:

- Problems of violence, uncertain territorial control and preoccupation with security tend to undermine government’s ability to formulate and deliver on poverty reduction efforts in conflict-affected states.

- Partnerships are also difficult in cases of low institutional capacity within governments due to lack of trained staff, inadequate administrative systems, or poor management.

1 The DAC describes partnership as involving, among other things, political commitments to poverty reduction by all partners: “The capability of a developing country government to make such a political commitment depends on its political system – in particular, how responsive the system is to the interests of poor people - and how well authority is consolidated within the state.” Cf. DAC (2002) Development Cooperation in Difficult Partnerships.

• Poor policy environments arise where governments are not committed to poverty reduction, and thus have failed to implement policy measures that promote growth and human development

• Governments with dysfunctional political systems tend to become focused on the sole issue of staying in power and are unable to deliver the political mobilisation to achieve poverty reduction goals

• The problems of poor policy and dysfunctional politics are frequently combined in repressive regimes that violate human rights, are unresponsive to the needs of poor people, and often have oppositional relations with donors

• Finally, it is important to note that poverty reduction partnership can fail due to ineffective donor engagement, including imposition of unrealistic policies, slow or unpredictable programming, and a failure to deliver on promised assistance

The issue of service delivery in difficult environments is important to DFID for at least three reasons. First, the MDGs will not be achieved without a strategy for service delivery in these contexts. It has been estimated, for example that as many as 50% of children out of school live in conflict affected countries. Second, service delivery may offer an entry point for triggering longer term pro poor social and political change. Third, service delivery interventions may help to prevent some of the states in this category from sliding into major conflict with repercussions for regional stability.

The health sector has been selected for focus in this study because this has a direct relationship with three of the Millennium Development Goals and it is a key sector for human development support in difficult environments.

3.0 Conceptual framework

This paper seeks to explore policy and operational issues that arise when a bilateral aid agency such as DFID seeks to support service delivery in a state that lacks either the will or capacity to facilitate the delivery of quality services to segments of its population. We will focus on three major issues for the donor community in these environments3:

Impact of services on poor people
The impact of service delivery interventions on the lives of poor people, regardless of context, is an important issue. However, difficult environments pose several challenges in relation to maximising the impact of services.

Firstly, ensuring that the poor and marginalised actually benefit from interventions is difficult in contexts where the risk of capture and diversion of resources is often quite high. Secondly, when services are principally delivered through a large number of non-state providers, achieving the widest

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possible coverage is difficult. In a post-conflict environment, coverage is especially important not only because the need for emergency relief is high, but as part of establishing stability and resolving conflict. Thirdly, highly decentralised delivery of services can also lead to inequalities. Service delivery interventions should consider how horizontal and vertical inequalities may be exacerbated and thereby fuel existing tensions or reignite conflict.

The question here is, how can service delivery interventions be designed and implemented to maximise their impact on poor people.

State legitimacy
Many of the states that fall into the difficult environments category lack either internal or external legitimacy. In the case of the former, the authority of the government can be contested by elements within its own population e.g. the Maoists in Nepal. In the case of the latter, the international community may refuse to recognise the government e.g. Burma.

It is problematic for the international development community to engage developmentally in these contexts as doing so may imply that existing state structures are legitimate. This might create tensions amongst international partners, or with some of the actors in any particular state context.

Conversely, the international community may want to support the internal legitimacy of a government, especially where a country has recently emerged from conflict. Support for service delivery can be a powerful tool to create stability and build peace in order to strengthen people’s belief in the state.

The question is, what forms and channels of aid exist that allow the international community to engage without necessarily legitimating the state or further aggravating existing social and political divisions? What forms and channels are appropriate when the objective is to strengthen state legitimacy and what are the implications for working with non-state service providers?

Sustainability
Sustainability is a central issue in any development context. The idea is that support for the service sector should lead ultimately to the re-establishment of public stewardship of basic service delivery. This may mean either that the state itself provides basic services, or that it works with partners in the non-state sector within a pro-poor regulatory and policy framework. Recently there has been some debate about whether or not sustainability can be realistically pursued in difficult environments.

By their very nature, difficult environments pose major challenges to introducing sustained institutional change – not least because the state and its partners lack individual, organisational, and institutional capacity. External partners may also lack the institutional capacity to work in these environments. We would argue that interventions that take long-term sustainability into account are particularly important in difficult environments because of its vital role in state formation and in securing peace and stability. The question here is, what mechanisms and approaches are most likely to
build the systemic capacity of the state to manage the delivery of services in the longer term, or at least not to weaken state capacity in the shorter term?

When considering the health service sector interventions in this case study, we will look at how questions of service delivery impact on the poor, state legitimacy and sustainability affect:

- The **form** of aid i.e. humanitarian or development funds, project funds or budgetary support
- The **channel** through which services are delivered i.e. non-governmental organisations, bilateral, or multilateral agencies
- The **systems** through which the aid is managed and policy is made i.e. line ministries, project implementation units etc.
- The **content** of the intervention i.e. infrastructure, capacity building

**4.0 Difficult environments included in the study**

This study uses illustrative examples from DFID’s approach to health service delivery in three difficult environments:

**Afghanistan:** Afghanistan is one of the poorest countries in the world and is emerging from over twenty years of external and internal conflict. There are continuing problems with security in several parts of the country and an estimated 60-80% of the population lives below the extreme poverty line. Currently, the Afghan Transitional Administration (ATA) is taking the lead in directing the development process through their National Development Framework. The success of ATA and the international community will be defined by the ability to generate a sustainable, safe and accountable Afghanistan state with the effective delivery of basic services.

**Nepal:** In 1996, the Communist Party of Nepal began what has become known as “the people’s war.” Armed incidents have increased and it is estimated that 5000 people have died since the start of the conflict. Support for the Maoists stems to some extent from the failure of the various Governments to implement social, economic and political changes to reduce poverty, eliminate corruption, provide employment, and deliver basic services.

Nepal may be classified as a difficult environment both in its failures of governance, security, and political legitimacy. The state has lost control of much of its territory and is unable to implement policy, including service delivery policy.

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4 Life expectancy is estimated at 44 years and the infant and maternal mortality rates, at 165 per 1000 and 257 per 1000 respectively, are amongst the highest in the world.
Burma: Burma is one of the poorest and most ethnically diverse countries in southeast Asia. There are significant disparities in the level of opportunities afforded to ethnic minorities in the country. Since 1960 Burma has been ruled by a series of military regimes. Democratic elections were held in 1990, but the ruling military junta refused to recognise the results. Burma has one of the worst human rights records in Asia. None of the criteria necessary for DFID to make a partnership with the government are satisfied (Country Strategy Paper, 2000). There is little government willingness to deliver services to the poor, especially in the border regions. Both education and health sectors are extremely under-funded.

5.0 The health sector interventions

5.1 Afghanistan – DFID support for the interim health strategy 2002-2004

Afghanistan’s health system is in poor condition. Since state capacity is weak, the limited delivery of basic services currently relies on a wide variety of actors – the UN, NGOs, civil society and the private sector. Support from the international community currently makes up about 80% of the health budget and NGOs and the UN support at least 60 per cent of the country’s functioning health facilities. Furthermore, because ATA has limited control over its territory, the delivery of basic services outside some of the main cities is patchy at best. The challenge is to address both short term needs for health services and the long-term goal of a state-run, sustainable health system. The model adopted by two of the main donors, the World Bank and the European Union, is to contract out service delivery to non-state actors through Performance-based partnership Agreements and to support the government in a stewardship role.

The Ministry of Health/ATA is seriously concerned about how to finance and ensure sustainability in the health sector in a post-conflict environment of very scarce resources and where capacity in policy and planning, and public health skills are weak. Although health is not the main area of DFID focus, DFID has supported a number of quick impact projects in the sector through CHAD. More recent support has sought to contribute to the sustainability of the health system through capacity building. This support fits into one of DFID’s core strategic areas in Afghanistan – technical support for public administration and economic reform.

DFID began its support to the Ministry of Health by funding a consultant to help senior managers develop, refine and prioritise policy issues. The secondment was followed by five further consultancies that supported the strategic and institutional development of the Ministry of Health. The consultancies focused on hospital management, human resource planning, budget development and accounting systems, health financing, and policy and institutional development. DFID has also provided a small amount of budget support that has enhanced working relations between the Ministry of Finance and the Ministry of Health.
The early results of these inputs were greater confidence among key MoH staff in discussing technical and management issues with development partners. The MoH is now increasingly confident in leading the health sector and laying the foundations for effective stewardship in the health sector. But financial sustainability and human resources remain a major challenge for the health system. The consultancies provided essential analytical work to supply the data needed to understand the scale of the challenge. An interim health strategy (2002-04) has been produced, including outline strategies in specific subject areas.

Opportunities exist for DFID to continue to support the health sector at central and provincial level in order to contribute to effective policy and planning processes. Support could usefully include health financing, budgeting, strengthening institutional capacity for policy and planning, including lesson learning from ongoing service delivery initiatives and strategic thinking around working with the private sector. This support would be most effective if closely linked with ongoing civil service reform.

In Afghanistan DFID is supporting the Transitional government through the Afghanistan Trust Fund in order to increase its legitimacy. The approach used is to strengthen the capacity of the Ministry of Health to develop policy and planning processes where there is a wide range of non-state providers. There are broader political aims in DFID’s capacity strengthening support for the Ministry of Health. While the support is developing the MoH’s policy and planning processes, it also contributes to the wider goal of state-building which is especially important in a post-conflict environment.

Building state capacity is essential because it will have an impact on peace and stability by increasing people’s belief in the state. Although this support to the health sector is relatively small, it will contribute to sustainability by enabling the ministry to eventually take over stewardship of the sector. However, given the context of insecurity and low coverage of services outside the capital, linking MoH support to service delivery activities on the ground will be a major challenge.

5.2 Nepal – Strengthening Health Services in Current and Potential Conflict-Impacted Areas

The ongoing conflict is impacting on the lives of Nepal’s most disadvantaged and marginalized groups. Although health facilities have not been a direct target, service delivery has been disrupted. The failure of the Government of Nepal to provide adequate basic health care and other services has been a key factor contributing to the conflict. The DFID-Nepal response to the conflict has three strands: long-term sustainable development programmes, projects that respond to immediate needs in high-level conflict areas, and humanitarian relief if it should become necessary.

DFID’s support to health services in conflict-impacted areas (July 2002-July 2003) aimed to ensure the availability of essential drugs, supplies and equipment at health facilities in certain districts. The project delivered
essential drugs and medical supplies to health facilities, contributed to the effective functioning of the cold chain, and ensured that there was adequate storage capacity. The aims of this particular project demonstrate some of the key issues in delivering services in difficult environments. Firstly, the project sought to mitigate the immediate effect of the conflict by restoring and maintaining health service delivery. But it also sought to contribute to conflict resolution by helping the Nepalese government to demonstrate that it can deliver effective services, thereby increasing its legitimacy with the local population.

The project used an instrument called Quick Impact Project (QIP)\(^5\) which DFID sometimes uses to jump start development in conflict situations. As its name suggests, it was meant to have a quick impact and to be implemented and completed in one year. Because it was developed as a quick impact project the design was based on existing knowledge of community level health care needs. There was little opportunity for consultation with the main target beneficiaries and other stakeholders.

The intervention deliberately used state systems for delivery, supporting the government with funding and supplies to reach previously unserved areas. The Ministry of Health and its Logistics Management Department was wholly responsible for the management of the project. This approach was possible because the Maoists have supported health service provision, and do not generally target government health workers and facilities.

The project was intended to demonstrate to those affected by the conflict that the government still has the capacity to deliver. Here, as in Afghanistan, there is a broader political aim behind working deliberately through state systems and not using the non-state sector. Increasing state legitimacy in conflict-affected or potential conflict areas may contribute to conflict resolution. But there are risks involved when a donor explicitly “takes sides”, especially when there may be some parts of the local community who support the Maoists.

It sought to work through government channels in order to avoid the creation of parallel systems. In the longer term, it is not clear how the basic supplies provided through the intervention (i.e. medicines and drugs) will be supplied once the project ends. There may be quick gains in delivering basic supplies through government channels but the difficulty of sustaining provision could in the long run provoke tensions. There is also the danger that non-target groups will capture the benefits of the project, resulting in the diversion of resources or bureaucratic blockage of inputs and activities.

5.3 Burma – Joint Programme for HIV/AIDS

Burma’s estimated 50 million inhabitants are threatened by an alarming HIV/AIDS epidemic. The situation is exacerbated by the country’s political isolation, which has contributed to chronic underdevelopment in the health sector. UNAIDS has identified Burma as one of the three high priority

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\(^5\) See GRC query on Quick Impact Projects, 20 August, 2003
countries in South East Asia. Trends in official surveillance data from 2001 show increasing rates of HIV infection among key sentinel groups: sexually transmitted infection patients, commercial sex workers, and pregnant women, among others.

Risk factors such as poverty, internal and external mobility, risk behaviours and a lack of response capacity means that there is potential for the epidemic to grow out of control unless an effective coordinated response is implemented. Furthermore, it is estimated that only $US0.09 per person per year is spent by the government on health and health related issues in Burma. This low spending level is reflected in the health indicators, which are poor compared to other countries in the region. Nevertheless, there remains some health system capacity with which the donor community can work.

In order to improve capacity in Burma for the prevention and care of HIV/AIDS, DFID is participating in the Joint Programme for HIV/AIDS: Myanmar, 2003-05, which involves bilateral donors, international financial institutions, and private entities pooling funds that are managed by the UN. The joint UN plan was developed as a unified effort among a number of active UN organisations including WHO, UNAIDS, UNICEF, UNDCP, UNDP, and UNFPA. Specific activities were identified and costed.

The programme has five components, based on priorities identified by implementing partners: reducing the risk of transmission of HIV, increasing awareness of HIV/AIDS among the general population, particularly young people, increasing access and quality of care, treatment and support for people living with HIV/AIDS. The intention behind synthesizing the priority areas identified by implementing partners is to address HIV/AIDS in a systematic and comprehensive manner.

Strategies for improving the quality of care, treatment and support for people living with HIV/AIDS include: a national basic package for care, guidelines and standards for treatment, enhancing capacity for screening and diagnostic services, and strengthening national capacities to provide effective counselling and support. Carrying out these strategies will involve working with lower levels of government and having policy discussions with Ministry officials. In fact some government ministries are listed as implementing partners – e.g. Ministry of Health, Education.

The UN uses a range of channels to work on the ground, including INGOs such as MSF, PSI, locally based NGOs and aspects of government. Interactions with government are limited and interventions support the training of local health workers, for example. Policy discussions with Ministry officials do take place. The decision was made to channel funds through the UN joint programme because this was felt to give more opportunity for coherence in approach than dealing with individual INGOs and NGOs. It is also simpler to hold the UN accountable for development outcomes.

How to effectively deliver public goods in a difficult environment, ensuring accountability and that the poor are reached by the intervention is a key issue.
This will require examining the relationship between government and local NGOs, as co-optation is sometimes a problem.

There are also questions regarding long-term sustainability. As there is very low public spending on health in Burma, how will the benefits of the programme be sustained? However, the coherence of the programme would potentially facilitate the state’s adoption of responsibility for the sector in the future. State stewardship of the sector would be a desirable outcome, as this would support the internal legitimacy of a new regime. State engagement also guarantees that service providers are accountable to their clients.

The question of government illegitimacy in Burma and what level of engagement donors ought to have will be key. It is particularly important not to be seen to be rewarding the government of Burma for poor performance. Therefore, DFID is working through the UN, which provides a more neutral way of engaging with the state. The UN is also seen as a key entry point in Asia. By investing in building the capacity of local NGOs and lower levels of government, it is hoped that a foundation can be built that can be capitalised upon should a change in government occur.

6.0 Issues
In this section we will identify key issues that need to be considered when designing and implementing service delivery interventions in difficult environments. Each of these affects the forms, channels, systems and content of the service delivery intervention.

6.1 The role of the state
The three interventions are atypical for service delivery in difficult environments in that they all involve working with government. The usual way of working in difficult environments is to deliver services outside of government channels through NGOs.

- **In Nepal,** at the time of the QIP the state was still one of the channels through which health services could be provided in conflict affected areas. More recently, the Maoists have become much more resistant to government involvement and alternative channels are being sought.

- **In Afghanistan,** there is general agreement that the state will not provide health services directly itself, but will monitor the provision of services by non-state providers. This role will become even more critical when services are contracted out.

- **In Burma,** the state has historically been a key provider of health services, but under the current regime systems have deteriorated, particularly in some of the ethnic minority areas. The HIV/AIDS programme is designed to build some capacity at the lower levels of the health system in order to prepare for a future scenario where the state re-engages.
These examples were explicitly chosen to highlight the importance in these contexts of working with the state in order to support sustainability and state legitimacy. Addressing these two issues is particularly important in difficult environments because peace and stability are often closely bound to the state’s internal legitimacy and its capacity to govern over the long term.

6.2 The role of non-state actors

When working in difficult environments, state capacity is often so weak that non-state actors are the most important channel for the delivery of services. There is a need to consider what role non-state actors will have and what effect they will have on state legitimacy and long-term sustainability.

- The Afghanistan example shows how technical assistance can be strategically used to enhance the capacity of the state to take on a stewardship role in relation to service delivery. A range of non-state actors actually delivers services and this is regarded as a viable model for the future.

- In Nepal, although the aid is channelled through government structures and systems, an international non-governmental agency is used to monitor and manage the programme. This is a short-term solution to capacity weaknesses in the government system.

- In Burma, in the absence of any acceptable role for central government the United Nations is the channel through which aid is delivered. This has led to donor harmonisation and a less fragmented response, but a parallel service delivery system.

6.3 Trade-offs

The final issue is how to maintain the balance between sustainability, having an impact on the poor, and building state legitimacy. Donors must recognize that emphasising any one of these may involve making trade-offs between the other two. The process for making these decisions needs to be open, deliberate, and as transparent as possible.

- DFID’s quick-impact project in Nepal implicitly sets the internal legitimacy of the state in front of sustainability. The trade-off between supporting state legitimacy and thereby conflict resolution, and the sustainability and effectiveness of delivery is clear. The intervention was designed to be completed quickly. But there are serious questions around sustaining provision of supplies and the risk of capture by non-target groups.

- In Burma, the challenge here was how to maximise the impact on those suffering from HIV/AIDS, while minimising the risk that the Burmese government would be legitimised in the process. The programme warrants further study to see to what extent marginalised
groups are being reached, whether state legitimacy is affected, and how it is sustained in the longer term.

- In Afghanistan, despite the fact that there are a large number of non-state providers in the health sector, coverage outside of Kabul is still very low. DFID’s intervention sought to build Ministry of Health capacity for policy and planning. The trade-off then lies in the choice between supporting the legitimacy of the ATA by building its capacity to deliver and formulate policy and contributing to delivering health care to the communities that are not yet reached by the system.

6.4 Politics matter

All of our examples highlight the importance of understanding the political context and the consequences of engaging in service delivery when state capacity to govern and control over its territory are contested or highly fragile.

- In Nepal, DFID’s decision to operate in conflict-affected areas explicitly seeks to build state legitimacy in Maoists areas in order to contribute to conflict resolution. The sector selected – health – is one which the Maoists found more acceptable for the government to be involved with. This would not be true in other sectors, such as education.

- Engaging in Burma was very politically sensitive for the UK. Public awareness of the illegitimacy of the Burmese government makes interventions quite risky. Care has been taken to minimise the risk of legitimating the state in the design and implementation of the intervention. HIV/AIDS is an acceptable sectoral intervention to both the ruling government and the opposition because it is regarded as a humanitarian crisis.

- The transitional government in Afghanistan came into authority after many years of protracted internal and external conflict. It is important for peace and stability that state formation and legitimacy is successful. The DFID support for MoH acknowledges this by working to build up the state’s capacity to formulate and implement policy.

Documents Consulted


**People Consulted**

Jenny Amery, DFID
Nick Banatvala, DFID
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