



Health & Fragile States Network



The Royal Tropical Institute

**Post-conflict health sectors:
the myth and reality of transitional funding gaps**

**Commissioned by the Health and Fragile States Network
Completed in collaboration with the Royal Tropical Institute**

October, 2008



Post-conflict Health Sectors: The Myth and Reality of Transitional Funding Gaps

Commissioned by the Health and Fragile States Network

**Completed in Collaboration with the
Royal Tropical Institute, Amsterdam**

October 2008

Authors:

Ann Canavan (Health Advisor, Royal Tropical Institute)
Petra Vergeer (Health Advisor, Royal Tropical Institute)
Olga Bornemisza (Secretariat, Health and Fragile States Network)

With contributions from:

Jacob Hughes (Independent Consultant)
Nadine Ezard (Independent Consultant)

Key Messages

- During the transition to post-conflict, the limited humanitarian health services that exist often come under threat of contraction. This is caused by a reduction in humanitarian funding for health combined with a slow inflow of development aid.
- Of the six post-conflict settings analysed, two experienced no funding gap (Afghanistan and Timor Leste), three had probable funding gaps (DRC, South Sudan and Sierra Leone), and one averted a serious funding gap (Liberia).
- Three determinants of transitional funding for health were identified: inadequate aid instruments, donor policy and priorities, and weak country governance.
- Whilst aid instruments were adapted to the transition, they did not always lead to adequate funding for health. Donor policy sometimes limited harmonization and strategic thinking, and geo-political priorities influenced the amount and timeliness of aid flows for health. Tensions between state-avoidance and state building were also important.
- There was very limited tracking of aid flows within the health sector which made it difficult to assess funding gaps. More aid tracking is required in these settings to allow for health actors to ensure that health services do not contract during the crucial post-conflict period, when populations are still very vulnerable.

ACKNOWLEDGEMENTS

The Health and Fragile States Network would like to thank the many people who contributed to this report. We owe a large debt of gratitude to the many people who agreed to be interviewed, and shared their wisdom, knowledge and experience of donor funding during the transition to post-conflict. To those who commented on the report, including Nichola Cadge, Fiona Campbell, Steve Commins, Egbert Sondorp and Jurriën Toonen, thank you for your time and effort. Finally, we would like to thank KIT and the consultant team who conducted the research, and both the U.K. Department for International Development and KIT who funded the report.

ACRONYMS

BPHS	Basic Package of Health Services
BPRM	Bureau of Population, Refugees and Migration (United States State Department)
CAP	Consolidated Appeals Process
CERF	Common Emergency Response Fund
CHAP	Common Humanitarian Action Plan
CHF	Common Humanitarian Fund
CIDA	Canadian International Development Agency
CPA	Comprehensive Peace Agreement
CPIA	Country Political and Institutional Assessment
CRS	Creditor Reporting System
DACO	Development Assistance Coordination Office
DFID	Department for International Development (United Kingdom)
DRC	Democratic Republic of the Congo
EC	European Commission
ECHO	European Commission Humanitarian Aid
EDF	European Development Fund
ERC	Emergency Relief Coordinator
EU	European Union
FBOs	Faith-based Organisations
FTS	Financial Tracking Service
GAVI	Global Alliance for Vaccination Initiative
GFATM	Global Fund for HIV/AIDS, TB & Malaria
GoL	Government of Liberia
HAC	Health Action in Crises (WHO)
HR	Humanitarian Reform
IASC	Inter Agency Standing Committee
ICRC	International Committee of the Red Cross and Red Crescent
INGO	International Non-Governmental Organisation
LRDC	Liberia Reconstruction and Development Committee
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDTF	Multi-Donor Trust Fund
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoHSW	Ministry of Health and Social Welfare
MSF	Médecins Sans Frontières
MTE	Mid-Term Evaluation
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
OECD-DAC	Organisation for Economic Cooperation and Development, Development Assistance Committee
OFM	Office of Financial Management
OFDA	Office of US Foreign Disaster Assistance
PEPFAR	President's fund for AIDS
PHC	Primary Healthcare
PMR	Project Monitoring & Review
PRS	Poverty Reduction Strategy
RCH	Reproductive and Child Health
SIDA	Swedish International Development Agency
UN	United Nations
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund

UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNMIL	United Nations Mission in Liberia
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRC	UN Resident Coordinator
USAID	United States Agency for International Development
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organization

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	IV
ACRONYMS.....	V
TABLE OF CONTENTS.....	VII
FIGURES.....	VIII
EXECUTIVE SUMMARY.....	IX
1. INTRODUCTION	1
1.1 STUDY RATIONALE.....	1
1.2 DEFINITIONS OF KEY TERMS	2
1.3 METHODOLOGY	4
2.0 COUNTRY CASE STUDIES: INVESTIGATING TRANSITIONAL FUNDING GAPS.....	7
2.1 LIBERIA	7
2.2 AFGHANISTAN.....	9
2.3 DEMOCRATIC REPUBLIC OF THE CONGO	10
2.4 SIERRA LEONE	12
2.5 SOUTHERN SUDAN.....	13
2.6 TIMOR LESTE.....	14
3.0 DETERMINANTS OF TRANSITIONAL FUNDING GAPS	16
3.1 THE NATURE OF THE AID INSTRUMENTS USED	16
3.2 DONOR POLICY AND PRIORITIES.....	21
3.3 IMPACT ON PREDICTABILITY.....	24
4. FURTHER RESEARCH AND CONCLUSIONS	24
4.1 PROPOSED RESEARCH AGENDA	24
4.2 CONCLUSIONS	25
BIBLIOGRAPHY	27
ANNEX 1 – TERMS OF REFERENCE	31
ANNEX 2 - SEMI-STRUCTURED INTERVIEW GUIDES: DONORS AND UN AGENCIES.....	36
ANNEX 3 - SEMI-STRUCTURED INTERVIEW GUIDE: NGOS AND MOH	37
ANNEX 4 - KEY INFORMANT CONTACT LIST	38
ANNEX 5 - LIBERIA CASE STUDY	40
ANNEX 6 - COMMON AID INSTRUMENTS IN TRANSITIONS	57

FIGURES

Figure 1: Patterns of Aid to Fragile States in Crisis	4
Figure 2: Donor support to the health sector in DRC (Global sources)	6
Figure 3: Donor support to the health sector in DRC (WB, UN and MOH)	6
Figure 4: Liberia Health Sector Transition Funding 2005-2008	7
Figure 5: Liberia: Shift from Humanitarian to Development Funds	9
Figure 6: International donor support to the health sector in Afghanistan (2002 – 2006).....	10
Figure 7: Estimated and projected donor support to health & HIV/AIDS programs DRC 2003-10..	11
Figure 8: Timor Leste Health Sector Aid Flows 2002-2006	15
Figure 9: Aid Mechanisms along the relief to development continuum.....	20

EXECUTIVE SUMMARY

Introduction

During the transition from conflict to peace, the limited health services that exist, mainly provided by humanitarian non-governmental organizations (NGOs), often come under threat of contraction. The most commonly cited reason is the so-called transitional funding gap, defined as a net reduction in monies available to the health sector during the transition from relief to development which may affect the delivery of health services. No studies to date have attempted to systematically analyse funding flows during transition, and the causes that contribute to this perceived gap. This paper was commissioned by the Health and Fragile States Network to examine these issues.

Transition in this paper is defined as when official development assistance (ODA)¹ flows change from humanitarian to development funding lines. This change influences the modalities and nature of health services delivered. This paper examines funding flows to the health sector during the transition to establish if gaps in funding and services actually occur or if, and how, they are averted. Secondly, it identifies obstacles to funding, and examines whether the aid instruments used in these settings hinder funding, or whether the problems are caused by a poor policy environment which undermines donor trust and thus funding allocations. The study does not consider the complex issue of how these changes relate to quality of health services and health outcomes.

The question of transitional funding is analysed as part of the broader question of aid effectiveness in post-conflict countries. It is argued that aid effectiveness is particularly important in these settings given the lack of government capacity and often extreme poverty. Furthermore, a reduction in of services as a result of a funding gap could be an indicator of aid ‘in-effectiveness.’

Methods

Secondary data sources were used to map out transitional funding in six post-conflict settings: Afghanistan, Democratic Republic of the Congo (DRC), Liberia, Sierra Leone, Southern Sudan, and Timor Leste (formerly East Timor). This included the Organisation for Economic Cooperation and Development, Development Assistance Committee (OECD DAC) Creditor Reporting System (CRS) for member state commitments for health sector development, and the UN Office for Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (FTS) for humanitarian donor commitments for relief efforts. In addition, 28 interviews were conducted with key informants from donors, UN, international NGOs, the International Committee of the Red Cross and Red Crescent (ICRC) and independent experts. Information from

¹ The OECD defines ODA as “Flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional in character with a grant element of at least 25 percent (using a fixed 10 percent rate of discount)” <http://stats.oecd.org/glossary/detail.asp?ID=6043> accessed 3 July 2008. This paper focuses chiefly on ODA reported by OECD-DAC donors, and as such does not capture some other important sources of funds such as non-OECD DAC donors (e.g. China), or other important sources of revenue such as foreign investment and diaspora remittances.

the interviews was triangulated with key findings from the literature and country level data where available.

Liberia was selected as an in-depth country case study as a gap had been anticipated in 2006, and substantive in-country work had already been done on funding flows by a team member on behalf of the Ministry of Health and Social Welfare.

Methodological constraints included the lack of reliable and complete financial tracking data to discern trends in aid flows in transitions. The major aid flow sources used included two global databases: UN OCHA FTS for humanitarian funds and the OECD-DAC CRS database for development funds. While improvements are noted in donor reporting of fund commitments, the discrepancies between pledges and actual disbursements were not discernible from the CRS. In addition, lump sum commitments were reported by year of allocation which distorts the aid tracking by country over time. Finally, not all sources of aid are included in these databases.

Poverty Reduction Strategy (PRS) documents and other in-country data sources were useful for aggregate social services commitments, but were not disaggregated for health. As a result, detailed aid flows disaggregated by sector could not be determined for any country analysed except for Liberia. This indicates a weakness in the financial tracking systems used. It was also difficult to tell, using financial data alone, whether transitional funding gaps occurred in these countries. Interview data and documentary evidence were therefore important in determining whether gaps occurred, or were perceived to have occurred and the reasons for this.

Was there a funding gap during the transition from relief to development?

Of the six settings analysed, two experienced no funding gaps (Afghanistan and Timor Leste), three had probable funding gaps (DRC, Southern Sudan and Sierra Leone), and one averted a funding gap (Liberia).

In Afghanistan, the findings suggest that there was no discernible gap in funding during the transition from humanitarian to development aid, and that development aid now eclipses humanitarian aid over five years into the transition. Political will and strong donor leadership were highlighted as key to the rapid scale up development funding for basic services delivered through the contracting-out to NGOs.

In Timor Leste, no transitional funding gap affecting the delivery of health services after the conflict was observed. A 2005 Mid Term Expenditure Framework (MTEF) revealed that the total funding to the health sector had been increasing over the past ten years. While a reduction in donor aid was anticipated, government funds were expected to increase due to Timor Leste's available oil revenues.

In contrast, findings from the DRC suggest that there is a transition gap. A recent World Bank (WB) Public Expenditure Review revealed a steady increase in development funds from 2003–2007, but a marked decline in humanitarian funding has led to a transitional funding gap. A fall in humanitarian funding (2006-07) has led to the abrupt withdrawal of some humanitarian NGOs resulting in reduced health service delivery. DRC's complex aid instruments coupled with donor geographic

stratification also challenge coverage and coordinated approaches to health service delivery; currently an estimated 83 out of 515 health zones have zero external financial support. In light of the evidence of a funding gap, donors, the Ministry of Health and the health cluster should examine funding amounts and mechanisms to see if the gap can be filled.

In Sierra Leone, it was not possible to determine if there was a transitional funding gap due to the difficulty of obtaining reliable information. Sierra Leone has witnessed a downsizing of humanitarian support to health services following the peace agreement in 2002, while key informants report that development funds are slow to arrive. The exit of a number of international NGOs due to lack of funding suggests that there may have been a funding gap. Further in-country aid flow analysis by donors and the Ministry of Health is urgently required to ascertain if there is a funding gap, and to adjust funding mechanisms and funding amounts if required.

In Southern Sudan, it was also not possible to obtain comprehensive funding trends. However, delays in the disbursement of the Multi-donor Trust Fund (MDTF), which accounts for 43% of total funding, are strongly indicative of a funding gap, as highlighted by NGOs interviewed. Donors such as the Office of US Foreign Disaster Assistance (OFDA), which supports over 50% of health services currently provided to NGOs, have extended humanitarian aid to try to fill the gap and sustain services for rural populations. Efforts to augment humanitarian funding and bridge the transition gap were also initiated by donors such as the UK's Department for International Development (DFID) through its Basic Services Fund and by the United Nations Development Programme (UNDP) through its recovery and rehabilitation program.

Finally, in Liberia, aid flow information revealed that there was no transitional funding gap. In 2006, a funding gap was a very strong threat, with humanitarian donors starting to leave the country and development funding slow to arrive. However, due to the recognition by both the Ministry and the NGOs, significant pressure, backed up by detailed analysis and projections, was put on the donors at the Washington Donors Conference in February 2007. Consequently, humanitarian donors agreed to continue to fund basic health services until the situation stabilized and the gap was averted.

Why Did the Situations Differ? Determinants of Aid Flows in Transition

There are numerous reasons why the transition from humanitarian to development ODA differs, with some situations seeing a smooth transition, and others experiencing more unpredictable funding. Reasons include the nature of the aid instruments used, donor behaviour and policies, and government capacity and legitimacy.

The use of appropriate aid instruments, including the adaptation of aid instruments to local contexts, emerged as major concerns. The choice of aid instruments reflects a continuum of state avoidance to state partnership. The mix and sequencing of aid mechanisms plays a key role in preventing a transitional funding gap to ensure a continuation of health service delivery while enabling concomitant health systems building.

There is an increasing tendency for donors to be more flexible with their aid instruments, which may improve transitional funding. Three different approaches are taken – adapting humanitarian instruments, adapting development instruments and creating new instruments. As an example of adapting humanitarian aid, the European Commission Humanitarian Aid department (ECHO) extended funding in Liberia when it was realised that withdrawal of its funds would result in a substantial gap in service delivery. ECHO also allowed funds to be used for more developmental approaches of capacity building rather than merely relief oriented service delivery. Donors also created new funding mechanisms, such as DFID's Basic Services Fund, which was developed to bridge the gap between humanitarian and development ODA funding lines in Southern Sudan. Overall, the study found that it is not the choice of an aid mechanism used in the transition from relief to development but rather the flexibility to adapt it, or the mix and sequencing of aid mechanisms that influence transitional funding flows. Donors who have to deal with the internal transfer of programs (OFDA to USAID, ECHO to European Development Fund) face particular challenges.

Donor behaviour and policy also influences transitional funding flows. Factors include the limited harmonization and strategic thinking between the humanitarian and development communities; how geopolitical interests influence the amount and timeliness of aid flows; and the tension between state-avoidance and state building, which is influenced by government legitimacy and capacity. Donors tend to be state-avoiding in post-conflict due to fiscal and governance concerns, although anomalies can occur where geopolitical interests supersede weak government capacity and willingness criteria measures. This is likely to be one reason why Afghanistan and East Timor did not exhibit a transitional funding gap, and development aid was available to replace humanitarian aid.

Government capacity and legitimacy play a major role in how quickly development funding flows into a country and humanitarian funding is withdrawn. The shift to development aid can be constrained by the absence of national recovery plans and health strategies, weak leadership and the differing political agendas of donors and governments. This in turn influences donor policy and can contribute to unpredictable aid flows in transitional settings. Unpredictability is challenging for longer term health sector planning, as seen in Liberia where funding levels of only two of the major donor sources are known beyond 2009.

Finally, NGOs are influential in terms of highlighting gaps, and in mobilizing resources to fill them. Whilst some NGOs were able to fill the gaps using their own funds, some NGOs faced closure at both primary and secondary healthcare levels in DRC and Southern Sudan due to marked shortfalls in humanitarian funds or major delays in donor disbursements. This resulted in large gaps in service delivery where the government did not have the resources for funding of the health facilities. NGOs with access to large amounts of their own funding can sometimes leave service delivery gaps when they depart due to lack of funding available to other NGOs or the government to take over their programs.

Implications and Conclusions

The study found that very little is known about funding flows for health during the transition to post-conflict. Routine fiscal tracking to the health sector is either weak or

absent in all the settings studied, with the exception of Liberia, where a dedicated aid coordination position exists within the Planning Department of the Ministry of Health. In some cases reliable information was not available (Southern Sudan, Sierra Leone), whereas in other countries information was collected at a certain point in time (i.e. Public Expenditure Reviews in DRC, MTEF in Timor Leste) rather than continuously.

This has numerous implications. It is difficult to assess whether transitional gaps have occurred, or to predict whether and when they will occur. This makes it complicated for health service providers such as NGOs and UN agencies, as well as nascent ministries of health, to take coordinated action and lobby for more funding. It also makes it hard for donors to harmonize and ensure major gaps in service delivery don't occur. Lack of knowledge about actual and future funding trends also presents major challenges for nascent governments who are faced with reconstruction of a fragmented or non-existent health system.

Weak planning and forecasting is thus common in transitions, undermining aid requests and results in gaps in service delivery. Overall, donor representatives and independent experts felt that the main issue in many post-conflict contexts is not the transitional funding gap *per se*, but rather lack of donor harmonization, a tendency towards aid volatility and alignment to national governments.

Overall, the emergence of new aid instruments, and the pragmatic adaptation of existing ones is encouraging and may help prevent future transitional funding gaps. More harmonized mixing and sequencing of aid mechanisms to ensure that both humanitarian and development activities are funded would also help. These changes could result in more timely and continuous disbursement of aid, increased aid flows targeted to health service delivery, and better linkages and communication between humanitarian and development funding bodies. However, there is still a need to explicitly recognize the obligation to continue to deliver health services, and to provide the necessary leadership to ensure that ODA, whether humanitarian or developmental, is available for this purpose during transition. More strategic, 'big-picture' thinking about continued health service coverage is therefore required by both humanitarian and development actors during transition.

A number of research gaps and opportunities were identified during the course of this study. More research needs to be done on both transitional funding and aid effectiveness in post-conflict countries. In-country studies would shed light on whether transitional gaps have occurred/are occurring, and the reasons for this. Specifically, more could be done in the DRC and Sierra Leone to better understand the funding gaps, and overall funding flows. Second, very little is known about the impacts of volatile funding and funding gaps on health services and health outcomes, and more studies are needed. Third, financial tracking services need to be strengthened; in particular they would benefit from research into why they remain under-utilized, and the impacts on decision-makers of the lack of data on which to base planning and forecasting. Finally, work could be conducted on aid mechanisms, in particular the benefits of flexible mechanisms and the adaptation of existing mechanisms to bridge the divide between humanitarian and development ODA.

1. INTRODUCTION

1.1 Study Rationale

In many post-conflict settings, there have been reports of humanitarian aid for health services being withdrawn before development aid is implemented, leading to a contraction of health services.² This paper examines funding to the health sector during the transition from relief to development to establish if gaps in funding commonly occur, and if so, why?

The paper was commissioned by the Health and Fragile States Network because there has been very little analysis of transitional funding, and its impacts on health services in the literature. It represents a first attempt to map out the nature of transitional funding in a systematic manner (Annex 1). Some recent papers have investigated donor allocations for humanitarian funding,³ other studies have focused on allocations to meet MDG targets,⁴ however, none have focused on the transitional funding gap. Capobianco completed a comprehensive study on health sector funding for Somalia (2000-2006) including allocative trends to different health priorities and geographical zones.⁵ This study found that even though committed funding to the health sector in Somalia almost tripled during this period, its *per capita* allocation was about US\$3, classifying it amongst the aid “orphans” of the Organisation for Economic Cooperation and Development, Development Assistance Committee (OECD-DAC). Capobianco highlighted the urgent need to track donor commitments to verify what is actually committed versus disbursed, and to provide information for planning and forecasting of aid flows, reflecting recommendations from recent reports on aid allocation policies.⁶

In addition, the aid effectiveness agenda, as outlined in the 2005 Paris Declaration⁷ and renewed by the recent Accra Agenda for Action⁸ and Kinshasa Statement on Fragile States,⁹ aims to enhance ownership, donor alignment to national governments, donor harmonisation, mutual accountability and managing for results. The Good Humanitarian Donorship Initiative¹⁰ and the OECD-DAC's

² Several papers including; Newbrander (2006), Suhrke & Afstad (2005), and Greco *et al* (2008) allude to funding gaps for health services across a range of fragile state countries.

³ Willits – King, B. (2007) *Allocating humanitarian funding according to need*.

⁴ Blanchett, K. (2007) *International Health and meeting the MDGs*.

⁵ Capobianco, E, Naidu, V. (2007). *A review of health sector aid financing to Somalia (2000-2006)*, World Bank.

⁶ OECD (2008). *Survey of aid allocation policies and indicative forward spending plans*. May 2008. OPM/IDL (2008) *Evaluation of the Implementation of the Paris Declaration: Thematic Study - The applicability of the Paris Declaration in fragile and conflict-affected situations*. Wood B et al (2008). *Synthesis report on the first phase of the evaluation of the implementation of the Paris Declaration*.

⁷ The Paris Declaration endorsed in March 2005 is an international agreement to which over 100 ministries, heads of agencies adhered and committed their countries and organizations to continue efforts towards effective delivery of aid with a set of monitorable actions and indicators.

⁸ Accra Agenda for Action was signed on Sept 4th 2008, as part of the Accra High Level Forum on Aid Effectiveness, and renews and takes forward the 2005 Paris Declaration.

⁹ Kinshasa Statement on Fragile States was developed by Roundtable 7 on Fragile States in Kinshasa (July 2nd 2008) in preparation for the Accra High Level Meeting.

¹⁰ Good Humanitarian Donorship Initiative

'Principles for Engagement in Fragile States'¹¹ make similar pledges around aid effectiveness. Gaps in funding and contraction of health services in post-conflict can be seen as an indicator of aid 'ineffectiveness'. An examination of transitional funding flows is one means of investigating whether the aid effectiveness agenda is being implemented in post-conflict settings.

This study assessed six recent post-conflict settings: Afghanistan, Democratic Republic of the Congo (DRC), Liberia, Sierra Leone, Southern Sudan, and Timor Leste (formerly East Timor). All are 'post-conflict' in the last ten years, and there were anecdotal reports of funding gaps in some. Two key questions were addressed in this report:

- What were the finance gaps (if any) and obstacles to funding as identified by stakeholders?
- What were the perceived determinants of transitional funding (gaps)?

The focus of the paper is on changes in humanitarian and development funding volumes. It does not consider the complex issue of how these changes relate to quality of health services and health outcomes. As a result, downstream impacts of changes in funding as perceived by recipient populations are not considered. These are, however, important questions that require further research.

1.2 Definitions of key terms

A country or area is considered to be **post-conflict** when active conflict ceases and there is a political transformation to a recognized post-conflict government.¹² The transition to post-conflict status is not linear, as political settlements often take years. Influenced by the nature of the political settlement and socio-economic status, about 40% of countries collapse back into conflict.¹³ Transition to post-conflict allows opportunities for rapid reform and renewed international engagement. It is often seen as a signal for humanitarian agencies to withdraw.

For the purposes of this paper, **transition** from conflict to post-conflict is defined from an aid perspective, not a political perspective. It is defined as when official development assistance shifts from humanitarian to development aid. This influences the amounts and modalities of funding and the types of health services delivered. Humanitarian aid is mainly focused on NGO service delivery, who provide the majority of health services in humanitarian situations, whereas development aid emphasises health system rebuilding and capacity development.

The OECD defines Official Development Assistance (**ODA**) as "flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional

¹¹ Principles for Good International Engagement in Fragile States

¹² World Bank (2007). *Strengthening the World Bank's response and long term engagement in fragile states*. Operational approaches and financing. IDA 15 Report, June.

¹³ Whaites A. (2008). *States in Development: Understanding State-building*, Draft Working Paper, Governance and Social Development Group, DFID. And World Bank, 2007, *Global Monitoring Report: Confronting the Challenges of Gender Equality and Fragile States*, WB, Washington.

in character with a grant element of at least 25 percent (using a fixed 10 percent rate of discount).¹⁴ This paper focuses chiefly on ODA reported by the OECD-DAC donors to the health sector, and as such does not capture some other important sources of funds such as non-OECD DAC donors (e.g. China), funds for humanitarian activities through military forces, additional diaspora remittances in response to crises, funds raised from the public by NGOs, corporate and foundation contributions and the contribution of affected states and their municipalities.¹⁵

Humanitarian aid is defined as funds reported by the UN Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (FTS). The definition of a humanitarian context used by the FTS is:

"The context in which aid reported to FTS can be considered humanitarian begins with an IFRC, UNHCR, or OCHA report, or comparable report or designation such as by the host government or donors, that confirms humanitarian needs. It is deemed to have ended when six months have passed with no IFRC, UNHCR or OCHA situation report that confirms current humanitarian needs."¹⁶

The FTS provides the best source of information on humanitarian aid to the health sector, although it relies on passive and often unreliable reporting.¹⁷ These data are limited to data reported to OCHA in humanitarian contexts, largely in response to consolidated appeals processes (CAPs) and other consolidated appeals.

Development aid is defined as development funds to the health sector, as reported by the OECD-DAC ODA Creditor Reporting System (CRS) database,¹⁸ excluding humanitarian funds which are also reported by the CRS but not by sector.

A **transitional funding gap** can occur when the funding lines shift from humanitarian to development aid, leading to cessation or disruption in aid flow that may affect the delivery of health services. The transitional funding gap has been schematically diagrammed in Figure 1.¹⁹

¹⁴ <http://stats.oecd.org/glossary/detail.asp?ID=6043> accessed 3 July 2008

¹⁵ Walker P and K Pepper. (2007). Follow the money: a review and analysis of the state of humanitarian funding. Feinstein International Centre, USA.

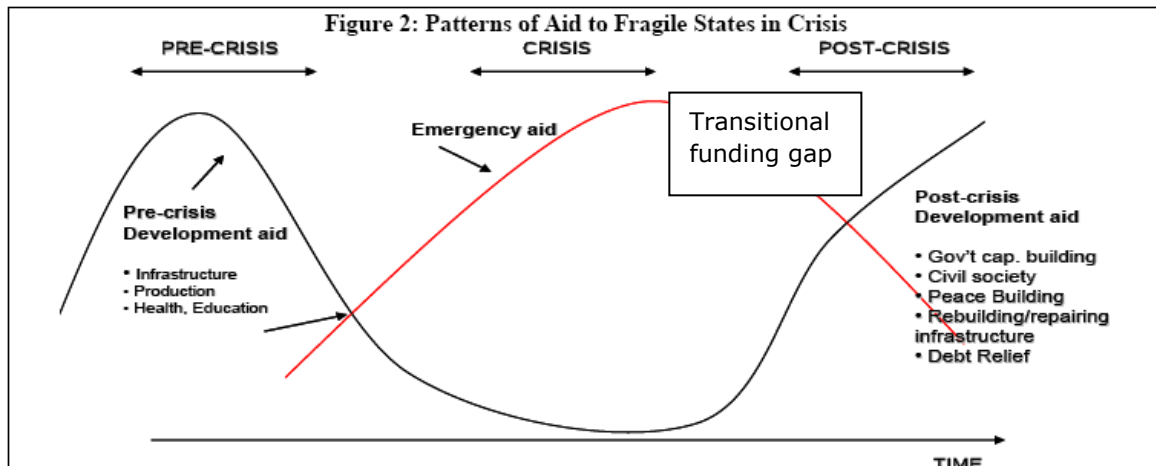
¹⁶ http://ocha.unog.ch/fts/exception-docs/AboutFTS/FTS_criteria_for_posting_contributions.pdf

¹⁷ Randel, J et al. (2005). Financing countries in protracted humanitarian crises; an overview of new instruments and existing aid flows. (In MacRae et al (2005), HPG Report No 18. Beyond the continuum, the changing role of aid in crises. ODI).

¹⁸ OECD DAC ODA Creditor Reporting System (CRS), health sector aid disbursement reported by donor.

¹⁹ World Bank (2007). *Strengthening the World Bank's response and long term engagement in fragile states*. Operational approaches and financing. IDA 15 Report, June. Note that the figure is simplified in terms of its linear time frame; in real cases, the nature of crises, particularly those caused by conflict, is much more complex.

Figure 1: Patterns of Aid to Fragile States in Crisis



This is distinct from other types of 'gaps' during transition, including gaps in stewardship, policy-making, and international interest.²⁰ This is compounded by the fact that the two types of aid do not necessarily target the same populations: humanitarian aid is usually targeted to the more unstable areas whereas development aid is targeted nationally, or to more stable areas within a country. There is also the overall 'health financing gap' which is the gap between the funds needed for a health system, estimated to be about \$34/person/year according to the 2001 Commission for Macroeconomics and Health, and the amounts available, which are sometimes as low as \$1-2/person/year.

1.3 Methodology

The study accessed secondary data sources for six regions (Afghanistan, DRC, Timor Leste, Liberia, Sierra Leone, and Southern Sudan) including the OECD DAC CRS for member state commitments for health sector development and the UN OCHA FTS for humanitarian donor commitments for relief efforts. The Development Assistance Coordination Office of the Government of Sierra Leone was searched for aid to Sierra Leone which tracks Poverty Reduction Strategy Papers (PRSP) funds based on six pillars, but does not disaggregate health funding. Other sources, used selectively to verify fund allocations in specific countries, included donor websites: the World Bank (WB), European Commission (EC), United States Agency for International Development (USAID), the UK's Department for International Development (DFID), and the Global Fund to fight AIDS, TB and Malaria (GFATM).

Secondary data on financial flows was complemented by 28 in-depth interviews with a cross section of key informants selected from donors, the United Nations (UN), international non-governmental organizations (INGOs), the International Committee of the Red Cross and Red Crescent (ICRC) and independent experts (Annexes 2-4). A balance was sought between head office and country level

²⁰ Surke, A. Ofstad, A. (2005). *Filling "the Gap": Lessons Well Learnt by the Multilateral Aid*. CMI Working Papers.

personnel. Information from the interviews was triangulated with key findings from the literature and country level data where available.

The study encountered various methodological constraints, most notably the lack of complete and updated financial tracking data to discern aid flow trends at the global level. Three major limitations were identified:

- Global financial tracking databases report retrospective donor commitments. In some cases, these are incomplete, as reflected in the literature.²¹ Most bilateral and multilateral donors are not consistent in global reporting of pledges, commitments and disbursements by sector, by country and by year. It may be feasible to discern trends through verification with other sources as seen in a recent study on maternal and child health allocations using the DAC database.²² However, this requires an extensive analytical process which was beyond the scope of this study, carried out in a limited time frame of 57 days. To obtain accurate year by year aid trends for the health sector, country level analysis by donor are necessary, as observed in the recent efforts for Somalia.²³
- Neither humanitarian nor development data sources provide data on actual expenditures, referring instead to commitments and/or disbursements. The latter provides a more meaningful measure of levels of aid invested, however: (a) it was not possible to disaggregate selected data according to health sector response and timing of aid flows; (b) reporting is uniquely linked to total commitments and does not reflect disbursements; (c) non-DAC donor contributions to selected countries are not reported; and (d) private funding sources are not reported, including NGO private funds, ICRC, diaspora remittances and contributions by the military. In addition, time-lags, overhead costs and utilisation of funds in other sectors than health can mean that actual health expenditure is less per year than described by disbursement data. Finally, data sources do not give any idea of projected funding.
- The OECD DAC ODA Creditor Reporting System is one source of health sector data for development aid but interpretation is made difficult by the fact that multi-year funds tend to appear in the year that they are allocated, which can skew the picture and imply a greater degree of volatility than in reality is the case. Figure 2 and Figure 3 below give some idea of this problem when comparing the global data sources with country specific sources for DRC.

²¹ Walker P and K Pepper. (2007). *Follow the money: a review and analysis of the state of humanitarian funding*. Feinstein International Centre, USA.

²² Greco G, Powell-Jackson T, Borghi J and A Mills. (2008). Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006. *Lancet* 371: 1268–75.

²³ Capobianco E. and V Naidu. (2007). A review of health sector aid financing to Somalia (2000 – 2006). World Bank Report.

Figure 2: Donor support to the health sector in DRC (Global sources)²⁴

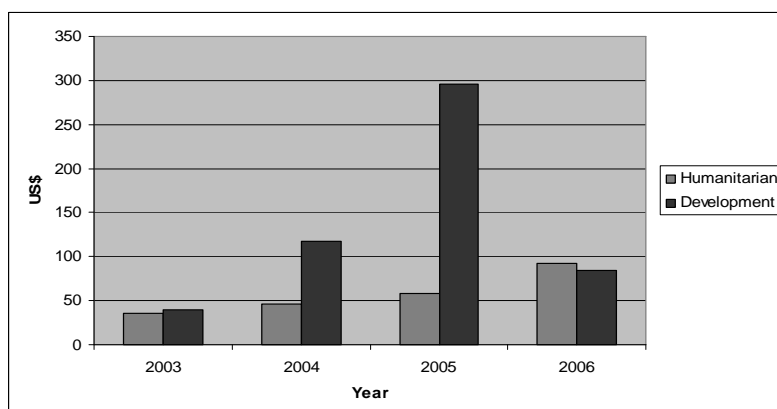
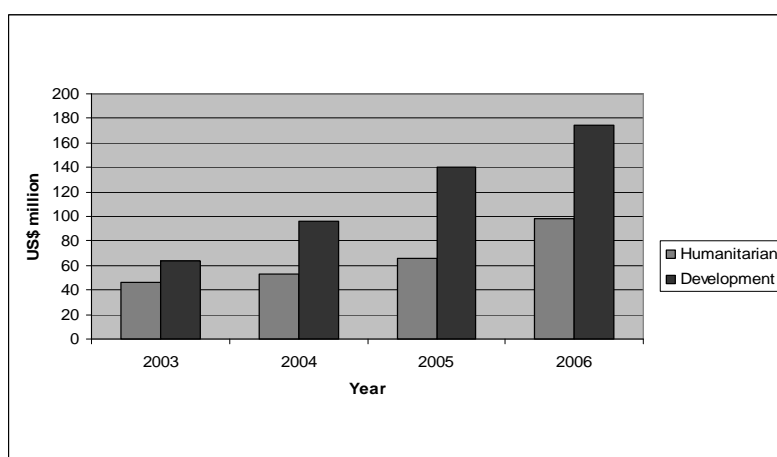


Figure 3: Donor support to the health sector in DRC (WB, UN and MOH) (in-country sources)²⁵



OECD DAC 2005 data suggests a total donor commitment of nearly \$300m compared to the in-country source data²⁶ of less than \$180m, as shown in Figure 2 and Figure 3 respectively. The in-country allocation (Figure 3) shows a more even distribution with a gradual increase from 2003-06, while global sources suggest an increase to 2005 followed by a sharp decline in donor commitments by 2006. This demonstrates the variability in aid tracking depending on extrapolation from global databases and specific studies of in-country aid flows which tend to be more accurate. Given the obvious disparities between global and national level data, the study extrapolates financial data from recent studies where available, and triangulates the data against qualitative information supplied by agencies.

²⁴ Source: UN OCHA FTS <http://ocha.unog.ch> generated 8 March 2008; OECD DAC CRS <http://stats.oecd.org> generated 4 March 2008; World Bank www.worldbank.org accessed March 4 2008.

²⁵ World Bank (2008). Public Health Expenditure Review (using data from MoH, donors and UN agencies).

²⁶ World Bank (2008). Ibid.

2.0 COUNTRY CASE STUDIES: INVESTIGATING TRANSITIONAL FUNDING GAPS

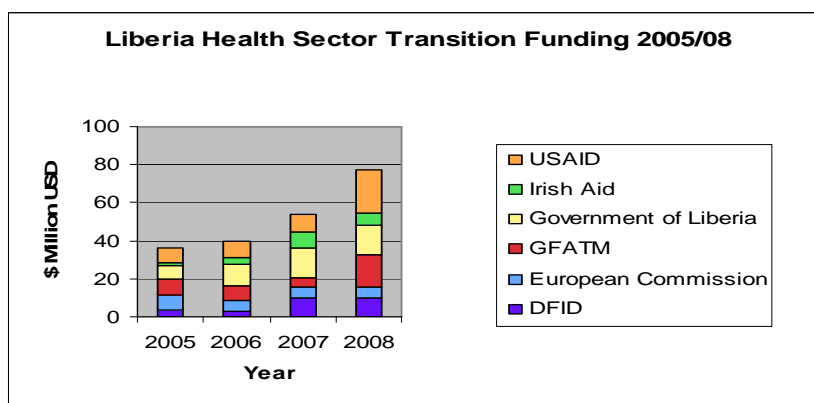
2.1 Liberia

An in-depth case study was done on transitional funding in Liberia (Annex 5). Liberia's health sector was strongly affected by the 14 year conflict as health workers fled and health facilities were looted and abandoned. Since the aftermath of the war, which ended in 2003, the country has taken a county health system approach. However, 77% of the functioning health facilities are still supported by INGOs. Whilst accurate information on health facility access and coverage is difficult to obtain, it was recently estimated that a total of 400 health facilities (HFs) are functional, out of a total coverage target of 550 HFs. A Basic Package of Services for primary healthcare has been developed and is in the process of being implemented in all facilities.

A previous study in Liberia, completed in Nov 2006, painted a grim picture of a population that, despite emerging from 14 years of conflict, was about to face a significant reduction in the delivery of health services due to the withdrawal of humanitarian aid and the delayed arrival of development aid.²⁷ There was only limited commitment on the side of the donors to fund basic health services and national budget allocations did not cover the gap.

The study done for this paper shows that the threatened transitional gap was averted. Overall levels of funding to the health sector increased in 2007, as shown in Figure 4. Aid commitments increased from \$36m (2005) to \$77m (2008) mainly due to increases in funding from Irish Aid, GFATM, USAID and ECHO.

Figure 4: Liberia Health Sector Transition Funding 2005-2008²⁸



This increase in funding was largely due to the identification of the potential funding gap in mid 2006, which was highlighted during the Washington Donor Conference in February 2007. The Liberian Minister of Health and Social Welfare (MoHSW) presented a compelling picture of what would happen if humanitarian agencies were to withdraw abruptly and donor funding to the health sector declined, while

²⁷ Msuya, C. Sondorp, E. (2005), *Interagency Health Evaluation Liberia, September 2005*.

²⁸ The table does not include all sources of funding. For purposes of presenting the health system funding over time, only major donor contributions and Liberian government funding is included.

indicating that the Ministry was not yet in a position to assume the full responsibility for financing, management and delivery of health services. This resulted in the extension of ECHO funding to its existing partners and increased contributions of Irish Aid and DFID to the health sector, as seen in Figure 4. The advocacy undertaken by NGOs and the support provided by donors to assist the MoHSW to draw attention to the situation during the Forum are thought to have played an important role in avoiding a more significant health funding gap.

As a result, health service delivery in Liberia has continued largely in the same manner as provided during the humanitarian phase in 2005 and 2006; the same health facilities delivered services with external support from NGOs.²⁹ Several NGOs interviewed mentioned experiencing delays in receiving funding during this period but none affected the actual delivery of health services as NGO's temporarily used other funds to ensure this continuation, with reimbursement as soon as donor funding became available.

The departure of different MSF sections in early-2007 resulted in the handover of primary health care clinics to other NGOs who then ensured further support. However, MSF's withdrawal from several secondary health care facilities in 2005-2006 created gaps which the Ministry was not able to meet. NGOs were unable to assume responsibility for the facilities, as they faced funding and capacity constraints in supporting secondary level health services.

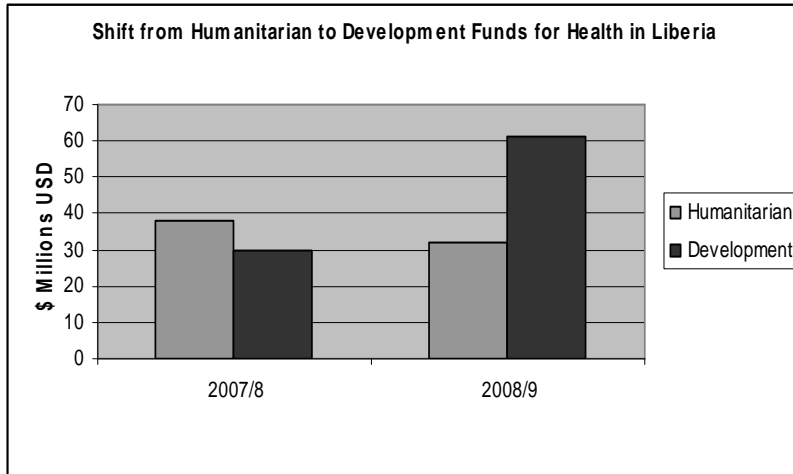
Figure 5 shows that a shift from humanitarian to development funding is anticipated during 2008/2009. Increases in health sector funding are attributed to development funding. This is also evidenced by the upcoming changes in institutional arrangements and approaches used by the donors, i.e. USAID is replacing OFDA, while DFID and Irish Aid plan a gradual shift from project aid to a more developmental approach of funding through a pooled fund with increased MoHSW ownership. The Global Fund (GFATM) will continue its support and the MoHSW is intended to become the recipient body and grant funds manager in 2009. ECHO is due to withdraw in 2009 succeeded by the European Development Fund (EDF) of the EC, and will contribute to the pooled funding mechanism. A national health plan has been developed which is generally supported by donors, and NGO proposals reflect its objectives. Nevertheless, donors highlighted that further refinements on timeframes and costing of the national plan are necessary to scale up to a sector-wide approach. The strengthening of aid coordination was seen as a vital aspect.

It is important to note that from 2007/08 to 2008/09, the amount of resources available for health service provision will not decrease, provided pooled funds are used for health service provision. UNHCR support to health services will cease at the end of 2008 and it is at this stage unclear who will take on this support. Contracting-out to NGOs will be piloted in 2009 and may, if successful, be a means of continued provision of health services through a public – private mix. However,

²⁹ It is difficult to determine current health service delivery coverage from a population perspective. MOH presentations state it to be 40% based on internal MOH staff assessments. The recent United Nations "Critical Humanitarian Gaps in Liberia: 2008" names 41% and refers to the 2007 LDHS, but the LDHS preliminary report does not seem to contain information on health service delivery coverage.

as noted by the Minister, this may be a short-term solution, and the question of long-term sustainability of services remains unanswered.

Figure 5: Liberia: Shift from Humanitarian to Development Funds³⁰



The delay in the availability of development funding, as well as the limited capacity of the MoHSW to deliver health services, led to the extension of humanitarian funding for another two years. It is plausible that this has delayed the transition from a humanitarian to development approach. Even with the formulation of a national health plan, health services in Liberia will continue to be delivered by humanitarian NGOs for the foreseeable future. Many NGOs highlighted that it is unclear how exactly the transition from humanitarian to development funding will affect them. Some NGOs mentioned that donors have asked them to provide an exit strategy in the upcoming year, whereas others noted that the MoHSW had expressed not being able to take over the service delivery role provided by NGOs for another five years. The development of negotiated exit strategies and associated clear roles and responsibilities for all stakeholders requires further attention in order to empower the MoH in its role as steward and regulator of the health system.

2.2 Afghanistan

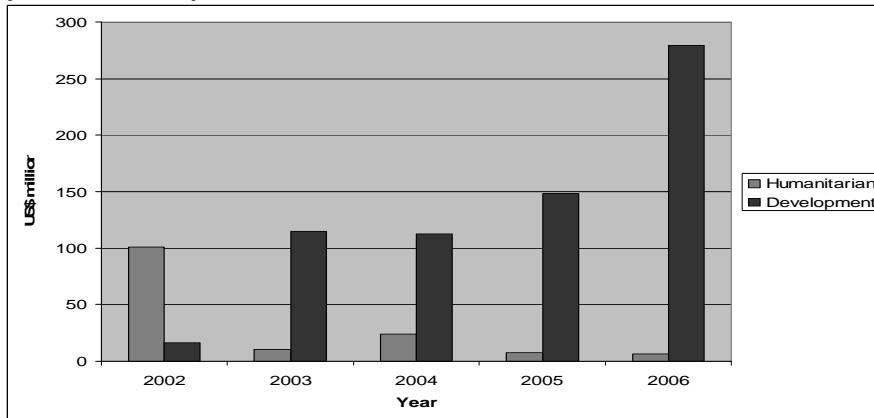
Following the fall of the Taliban in 2001, NGOs accounted for 80% of health facility coverage. Donors, including the EC, WB and USAID, supported the development of a streamlined approach to service delivery in the form of a basic package of health services (BPHS) which they agreed to fund. Services are now largely delivered through contracting-out to NGOs with the Ministry of Public Health (MOPH) responsible for stewardship, including policy, standard setting and regulation. Reported health service coverage increased from 9% in 2002 to 82% in

³⁰ This includes all known sources of health financing in Liberia, except estimated out of pocket payments.

2006, although out-of-pocket expenditure remains high.³¹ Essential hospital services are still rudimentary and in need of strengthening. Vertical programs receive global fund support for HIV, TB and malaria.

Whilst there was a decline in humanitarian aid post-2003, there was an overall increase in development aid, consequently no transitional funding gap was observed (Figure 6).

Figure 6: International donor support to the health sector in Afghanistan (2002 – 2006)³²



Donor and NGO representatives highlighted the importance of political will, and strong donor leadership that resulted in full commitments to fund contracting-out a BPHS. The provision of basic services through a government endorsed BPHS package has resulted in alignment of agencies supporting the health sector. Despite the absence of a transition funding gap, secondary and tertiary services are under-funded. A MoH representative interviewed estimated an additional US\$100M was required, particularly for an essential package of hospital services which currently has only 50% national coverage. Despite these problems, Afghanistan is an example of a relatively successful transition from humanitarian to development funding.

2.3 Democratic Republic of the Congo

Historically, DRC benefited from a functioning health system largely supported by faith-based NGOs. This was decimated during the protracted crises, starting in the 1990s, leading to chronic under-funding of services. Today, the DRC's health system is very fragmented, characterised by a decentralised approach with faith-based NGOs accounting for over 50% of PHC services. Health operational units known as health zones (totalling 515) cover a total population of 57m. Health

³¹ Sabri, B., Siddiqi, S., Ahmed, A.M., Kakar, F.K., Perrot, J., Towards sustainable delivery of health services in Afghanistan: options for the future, Bulletin of the World Health Organization 2007; 85:712–718.

³² Source: UN OCHA FTS <http://ocha.unog.ch> generated 8 March 2008; OECD DAC CRS <http://stats.oecd.org> generated 4 March 2008; World Bank www.worldbank.org accessed March 4 2008.

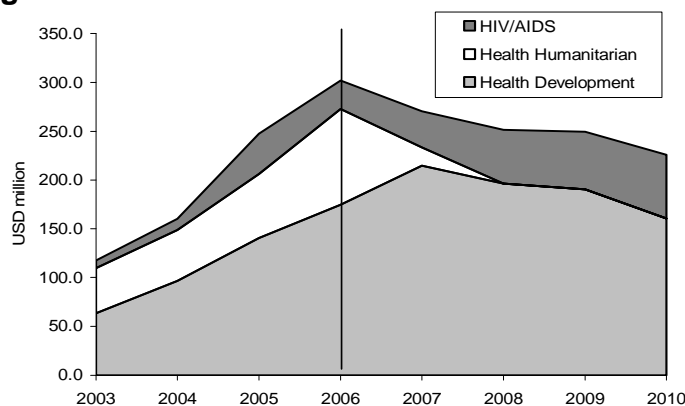
zones are responsible for management of primary and referral health services but suffer from lack of skilled health workers and virtually no direct resources from the government. They are thus reliant on external donor assistance and out-of-pocket expenditure; government revenue for the health sector is currently estimated at only 2-3% of total revenue. Humanitarian agencies continue to respond to the chronic humanitarian crises in the east.

International health sector engagement in DRC is complex, making it difficult to coordinate approaches and achieve sufficient coverage.³³ The MoH has a total of 52 program offices with an equal number of supporting aid mechanisms including multilateral (UN, WB), bilateral (DFID, EC, USAID, Belgium), and global health initiatives (GFATM, GAVI, PEPFAR). These are stratified by administrative and geographic areas. USAID support faith-based consortia projects at district and health zone levels, whereas the EC supports provincial health system strengthening, and the World Bank supports contracting-out of services through a health systems strengthening initiative at health zone level. An illustration of the country's lack of basic, equitable financing is evident in the current estimation that 83 of 515 health zones have no external donor support.

According to data sources for the DRC health sector, total volumes of international aid support are low, and vary by province, ranging from US\$2 to \$4.50 *per capita* in 2006. Government health expenditure is considered low at US\$0.80 *per capita* in 2006; even allowing for a doubling of the amount of 2003, it is still one of the lowest globally. It is not surprising then, that out-of-pocket expenditure is high, with user fees providing 60% of the main income for health facilities and drug sales supplying another 25%.³⁴

Analysis of funding data to DRC for the period 2003-2010 shows an overall increase in international aid to the health sector up to 2006. However, this is followed by a decline in humanitarian expenditure without a predicted increase in development expenditure (Figure 7).³⁵

Figure 7: Estimated and projected donor support to health & HIV/AIDS programs DRC 2003-10



³³ Stoddard A, Salomons D, Havers K, Harmer A (2007). *Common Funds for Humanitarian Action in Sudan and the Democratic Republic of the Congo: Monitoring and Evaluation Study*.

³⁴ Ibid.

³⁵ World Bank (2008). *Democratic Republic of Congo Public Expenditure Review*. Page 114 (using data from MoH, donors and UN agencies).

NGOs interviewed highlighted that the abrupt decline in humanitarian assistance has had immediate adverse effects on health service delivery, providing the example of ECHO's withdrawal in western DRC in 2003 with a two year funding gap before the EU development program assumed funding responsibility. Some NGOs experienced a downscaling of funds in eastern DRC due to delays in donor transitional funding. The WB Public Expenditure Review (2007) cites the repercussions on health service utilization in one health zone in DRC:

“.....while it was supported by a humanitarian NGO, the Wendji-Secli Health Center provided 50 consultations daily. When a development program took over the humanitarian project, direct incentive payments ceased and the provision of free drugs to the patient stopped because drug sales (at subsidized prices) were used to finance remuneration for staff. The number of daily consultations went down to 25. Currently, there is no external support, so there are 15 consultations per day.”³⁶

Overall, the study found that there is a high probability that there is a transitional funding gap in DRC, with a subsequent reduction in health service delivery. In light of the evidence of a funding gap, donors, the Ministry of Health and the health cluster should examine funding amounts and mechanisms to see if the gap can be filled.

2.4 Sierra Leone

Sierra Leone's rating on the UNDP Human Development Index is the second lowest in the world with a GDP *per capita* of \$600 and over 70% of the population of 5.5 million live under the poverty line of \$1 per day. A decentralized health system is in operation with over 40% of district based services supplied by NGOs. Following the end of a ten year civil war in 2002, Sierra Leone's recovery strategy was developed to serve as a bridge from humanitarian assistance to development. A National Health Plan was developed in 2002 and this is supported by a donor backed PRSP (2004).

However, following the peace agreement in 2002, Sierra Leone has witnessed downsizing of humanitarian support to health services.³⁷ Key informants reported that development funds have been slow to arrive, highlighting the withdrawal of at least two health INGOs from Sierra Leone due to termination of funding. The impact on health service delivery was not further assessed in this study.

The provision of health sector budget support from donors is significant, accounting for 20% of the overall budget (2005). In addition, 26% of total aid is channelled to NGO projects, the major donors being the EC (the largest donor of NGO project aid), and Irish Aid (project aid). The Global Fund's pledge has now reached a total of \$56m. Recent efforts to mobilise resources in support of achieving MDG 4 and 5 was marked with the recent launch of a new Reproductive and Child Health (RCH)

³⁶ World Bank (2008). Democratic Republic of Congo Public Expenditure Review.

³⁷ According to the Development Assistance Coordination Office (DACO).

strategy (2008-10) with funds pledged by World Bank, DFID and technical assistance from UN agencies. The development of the strategy has fostered alignment and harmonisation as all health agencies participated in the process and provided technical assistance to the MOH in development of the strategy. However, concerns have been raised about the capacity to implement the strategy and the timeframe in which funds will be released.

The first National Health Accounts were developed in 2007 but donor representatives indicated they may not include significant funding sources that have been committed. The MOH proposes to undertake a public health expenditure review complemented by a health financing study in 2008-09 with particular attention to user fees in view of the high out-of-pocket expenditure of 69% in 2006.³⁸ Given the paucity of financial data available, it was not possible to determine if there was a transitional funding gap. Further in-country aid flow analysis by donors and the Ministry of Health is urgently required to ascertain if there is a funding gap, and to adjust funding mechanisms and funding amounts if required.

2.5 Southern Sudan

Southern Sudan's health system is being reconstructed following the end of twenty-three years of civil war. International support to a newly formed Ministry of Health (MoH) commenced with undertaking a Joint Needs Assessment, and the development of a multi-donor trust fund (MDTF) framework for the delivery of basic services, managed by the World Bank and supported through a joint donor initiative formed by five European donors. A decentralized health system was developed in which ten states are responsible for the management of services which will be contracted-out to the private sector.

Over three years since the signing of a Comprehensive Peace Agreement, Southern Sudan continues to struggle with overwhelming needs, poor infrastructure and a virtual absence of capacity at the county level to provide essential services. Based on the limited sources of aid flow information, it is not possible to determine if there is a transitional funding gap as data on bilateral and private sources of funding for Southern Sudan health sector were not readily available. A consultant to the Southern Sudan NGO forum explains: "...it has not been possible to undertake a comprehensive funding analysis...given the difficulty of accessing complete and accurate information, the multi-year nature of some of the funding sources and the sheer magnitude of the task".³⁹ However, due to the importance of this information for planning purposes, the World Bank is currently supporting the MoH to undertake a full scale health financing review which will include an institutional assessment of government capacity at central and state level for budget management and administration.

³⁸ National Health Accounts (2007), Ministry of Health, Sierra Leone.

³⁹ Fenton, W. (2008). *Funding mechanisms in Southern Sudan; NGO perspectives*. Commissioned by the Juba NGO forum.

NGOs indicated that delays in disbursement of the MDTF, which accounts for 43% of multi-sector donor aid currently committed to Southern Sudan, have led to health service delivery gaps. Government expenditure for health remains at 8% since the establishment of the transition government in 2005. Health service coverage has not improved, and may in fact be declining. Humanitarian aid to internally displaced people and returnees is provided by ECHO and OFDA, however phase out commenced in 2007. As in Liberia, USAID/OFDA and ECHO have increased their humanitarian aid levels to ensure continued support to basic service delivery over the previous years, thereby "...stretching both the conceptual and administrative limits of emergency and humanitarian funding sources..."⁴⁰ This is important as direct project funding to NGOs accounts for 86% of available health services in Southern Sudan, with an overall basic health service coverage estimated at 40%. Referral services are virtually non-existent with the exception of a few faith-based hospitals. There are few opportunities to increase coverage until the MDTF disbursement to private contractors commences, which is expected to happen later in 2008.

As a donor representative in Southern Sudan stated:

"We need a mix of funding: as the MDTF is only now beginning to deliver, people are impatient and looking at quick fixes. At the same time the humanitarian funding should continue direct to NGOs. There is no magical transition period, that you switch on and off, it takes a long time".

In addition to MDTF funds, DFID introduced a bilateral bridging fund to guarantee coverage of basic services, the Basic Services Fund (US\$40m). The UNDP Recovery and Rehabilitation Program committed a first phase of \$70m with a further \$70m committed for a second phase from 2009. However, UNDP recovery funds are also challenged by administrative delays while unable to address the scale of needs as identified in joint assessment missions.⁴¹

Overall, donor mapping is weak in Southern Sudan and access to reliable aid flow data is difficult. Efforts are under way to improve monitoring of bilateral and pooled aid by the Joint Donor office. Until this occurs, it is difficult to obtain comprehensive funding trends, however delays in the disbursement of the MDTF are strongly indicative of a funding gap, as indicated by NGOs.

2.6 Timor Leste

Following independence from Indonesia in 2002, Timor Leste's health system needed to be rebuilt as about 35% of the health facilities were destroyed during the withdrawal of the militia's post-election. During the initial phase, health service provision was provided by relief-oriented NGOs (1999-2002) which shifted to district service provision through the use of district health plans. The model of

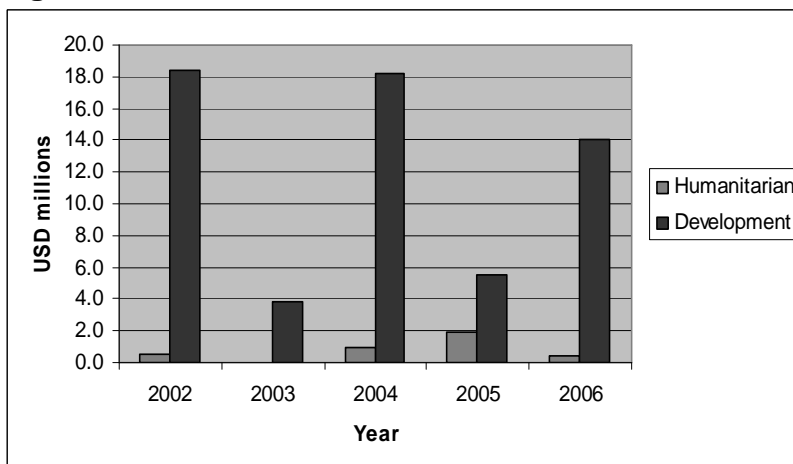
⁴⁰ Fenton, W. (2007). *Treading a delicate path: NGOs in fragile states. Case study Southern Sudan*. Save the Children UK. London. P.6

⁴¹ Refugees International. *South Sudan: Key facts on funding recovery needs*. OpenDocument accessed March 26 2008

contracting external NGOs was explicitly rejected by the government.⁴² Early decisions on downsizing of the health system led to a reduction of fixed health facilities from 406 (prior to 1999) to a planned 158.⁴³ Many INGOs left while some more developmental (local) organizations provided support.

Retrospective data and interview sources concur that though there were fluctuations in *per capita* aid by year there was no net financial gap during the transition period (Figure 8). The main emergency donor in the health sector, ECHO, provided direct funding to NGOs to support basic services and district health plans (US\$10-15m over 2 years until mid 2001). Bilateral funding of US\$10 million was provided for mental health, dental care, HIV/AIDS and TB control.⁴⁴ Centralised planning and support was provided through a multi-donor trust fund – the “Trust Fund for East Timor” (TFET). Managed by the World Bank, it totalled US\$12.7 million in June 2000 and was allocated for the construction of community health centres, with an additional US\$12.6 million in 2001 for hospital reconstruction. In addition, US\$7.5 million was provided through the Consolidated Fund for East Timor (CFET) to support the budget to pay for salaries and other recurrent costs. Coordination was led by the government and the fund was administered by the UN. While the MDTF was set up relatively quickly and was generally considered successful, procurement procedures were difficult hampering access to essential funds.⁴⁵ Despite this, no disruption in health service delivery was reported.

Figure 8: Timor Leste Health Sector Aid Flows 2002-2006⁴⁶



Conflict broke out again in early 2006, which resulted in more than 3,000 homes burnt and 15% of the population displaced. Health services continued to be provided by the MoH and most stakeholders involved in the health sector

⁴² Waldman R. (2003) *Rebuilding health services after conflict: Lessons Learnt from East Timor and Afghanistan*. ODI. <http://www.odihpn.org/report.asp?id=2567>

⁴³ Tulloch J, Saadah F, de Araujo R, de Jesus R, Lobo S, Hemming I, Nassim J, and I Morris. (2003). *Initial Steps in Rebuilding the Health Sector in East Timor*. National Academic Press.

⁴⁴ Tulloch *et al*, Op Cit.

⁴⁵ Tulloch *et al*, Op. Cit.

⁴⁶ Sources ; [OCHA FTS, OECD DAC CRS](#) accessed 6 March 2008; [OECD DAC CRS](#) generated 4 March 2008

highlighted its resilience to deal with the crisis. Many of the camps are still present in Dili, while the instability and insecurity continue.⁴⁷

A national health plan has been developed more recently which describes a basic package of services. Its implementation is the Ministry's priority together with a more community based outreach approach to deal with the low utilisation of health facilities, said to be less than 50%.⁴⁸ Donors support the national health plan although coordination is more informal than MoH-led. Capacity has been limited within the MoH, leading to a high number of international technical advisers providing support.

Overall, Timor Leste has been cited as a success in health sector transitions, and no funding gap occurred. Its recovery after 2002 was notable as it had immediate buy-in by donors for a coordinated workplan which cemented the health system recovery approach. Success has been attributed to excellent donor coordination, strong leadership, comprehensive health planning focused on a basic but flexible common work plan, and alignment of national authorities and donor strategies.

3.0 DETERMINANTS OF TRANSITIONAL FUNDING GAPS

There are numerous reasons why some situations experienced a funding gap, whilst others did not. These include the nature of the aid instruments that are used, donor behaviour and policies, and government capacity and legitimacy. These factors influence both the amount and predictability of funds, as well as how the funding is used.

3.1 The Nature of the Aid Instruments Used

Adaptation and creation of new instruments

Quickly changing transitional situations require flexible aid instruments that can disburse funds quickly, predictably and with longer funding cycles than the traditional six month funding cycles of humanitarian aid.⁴⁹ Aid instruments, although traditionally classified as being either humanitarian or development oriented, often become hybridized in transitions, or are used in parallel. Three different approaches can be identified:

1. Adjusting humanitarian aid instruments by extending project cycles, and emphasizing development approaches such as vulnerability analysis, community participation, empowerment, and capacity building.⁵⁰

⁴⁷ Zwi A, Martins J, Grove N, Wayte K, Martins N, and P Kelly. (2007). [*Timor-Leste Health Sector Resilience Study*](#). Sydney: The University of New South Wales.

⁴⁸ A health seeking behaviour study is in the process of being carried out.

⁴⁹ Leader, N. Colenso, M. (2007). *Aid instruments in fragile states*. PRDE Working paper No 5.

⁵⁰ J Macrae and A Harmer (eds) 2004. Beyond the continuum, the changing role of aid in protracted crises. HPG Report 18. ODI: London.

2. Extending development funding to transitional settings and disbursing funding through government as well as non-state actors (e.g. ICRC, INGOs, community and faith-based organizations and 'independent service authorities'). This approach is in line with the call for more flexible funds that are loosely earmarked and more predictable.⁵¹
3. Establishing new instruments to fund health projects in transitional settings, such as the EC's Humanitarian Plus, and The World Bank's Trust Funds.⁵²

1. Adjusting humanitarian aid instruments

Humanitarian aid instruments can be adjusted so that they are more 'developmental' in nature, however this approach has had variable results. Pooled humanitarian funds (see different types of aid instruments in Annex 6), such as the Common Humanitarian Fund (CHF), have shown a degree of success in gap filling in the DRC and Sudan but were undermined by slow administration. The original aim of the CHF was to harmonize jointly identified needs with service delivery outputs whilst decision making became more inclusive. However, NGOs reported exclusion from the fund, and indicated that it remained UN centric,⁵³ which may have negatively impacted on health service provision in Southern Sudan and DRC where NGOs provide the bulk of primary health services. In Liberia, ECHO adapted to the perceived funding crisis; after much lobbying, funding was extended when it was realised that withdrawal of its funds would result in a substantial gap in service delivery. ECHO also allowed funds to be used for more developmental approaches of capacity building rather than merely relief oriented service delivery.

Some critiques of adapting humanitarian instruments are that they still retain inappropriately short project cycles which include exit plans that can result in health service delivery gaps, and have limited long-term capacity building components.

2. Extending development funding to transitional settings

Development instruments can be adapted to post-conflict settings. These include MDTFs and sector pooled funds, direct budget support, global health initiatives and technical assistance.

MDTFs and sector pooled funds, which are managed by donors, can be a catalyst for improved coordination and creating an enabling environment for development. This was found to be the case in Liberia, where a sector pooled fund has been initiated through support from DFID. Equally, Afghanistan has reported positive results on the Afghan Reconstruction fund, though not specifically targeting the health sector. The Southern Sudan MDTF has met with mixed results; NGOs view it as an inappropriate instrument for the transition due to its very slow rate of disbursement, and various staffing, structural and management issues.⁵⁴ On

⁵¹ Harmer, A. Stoddard, A. (2006) *Review of GHD domestic strategies*.

⁵² Randel, J et al (2005), *Financing countries in protracted humanitarian crises; an overview of new instruments and existing aid flows*. These are being replaced by a new 'State and Peace-building' Fund.

⁵³ Stoddard et al (2007) *ibid*.

⁵⁴ Fenton, W. (2008). *Funding mechanisms in Southern Sudan; NGO perspectives*. Commissioned by Juba NGO forum.

the other hand, the joint donors and the World Bank, who have invested in pooling the funds and providing technical assistance respectively, are eager to ensure its success. The government recognises its potential for leveraging funds to support the national health strategy and capacity building of their institutions, but is equally frustrated by the slow start up and failure to provide the long awaited peace dividends following a protracted war.

Sector pooled funding mechanisms promote enhanced collaboration between all stakeholders in a transition, but can also be subject to bureaucratic delays that hinder basic service provision and capacity building of fledgling health ministries. Pooled funds are still relatively new as instruments in transitions; they are likely to continue given the level of government and donor interest and potential to improve harmonisation and alignment. Efforts to adapt operational procedures (finance, procurement, administration) to post-conflict are in progress and are urgently required if much needed health services are to be delivered without extended gaps.

Direct budget support or sector budget support to MOH's budget, offer increased opportunity to align aid to national priorities. They can also contribute to policy alignment, rational allocation of resources and improved government ownership. However, budget support is not a first choice for many donors in post-conflict settings due to loss of control over funds and accountability, risk of fungibility and misappropriation, and explicit state avoidance due to donor government political choices. In the medium to long term, donors recognise the need to shift to sector budget support that assists in legitimising a nascent government. However, they are reluctant to commit funds where the financial and administration systems are weak, thus there are few examples where direct budget support has been deployed in the context of post-conflict health sector recovery.

Global health initiatives, such as the GFATM, have recently scaled up in fragile contexts, and have invested significant resources, particularly for HIV/AIDS. Increasingly there is recognition of the need to strengthen health systems in order for vertical programs to scale up. However, limited funds are expended on health systems strengthening e.g. for GFATM advise that up to 15% of the total budget can be expended on health system strengthening while in practice, current figures report that only 1% has been allocated to health systems strengthening.⁵⁵ Global funds have the potential to create separate mechanisms for funding and delivery, complexity of applications and implementing procedures with and labour intensive monitoring processes.

Technical Assistance is used in many transitional settings and is an important adjunct to budget support and other aid instruments. Technical assistance (TA) to governments is required to assist in conceptualization of recovery strategies and choice of preferred aid modalities. However, it is often delayed and *ad hoc*. Good TA can assist with highlighting to both donors and national government the need to maintain health service coverage for vulnerable populations, and devise funding and delivery mechanisms to assist with this.

⁵⁵ Global Fund (2007) *Partners in impact: Results Report*

3. Establishing new instruments

There is increased recognition by donors of the limitations of existing aid instruments, thus efforts are being made to develop new aid instruments that are better suited to transitions - i.e. that disburse funds quickly and in a predictable manner with longer funding cycles, and fund both health service delivery and capacity building and health system strengthening. Some donors are piloting new aid instruments that allow for more rapid disbursement of funds.

For example, the principle aim of the EC's 'Linking relief rehabilitation and development' approach is to promote a shift from service delivery focused projects to one that strengthens government and civil society engagement.⁵⁶ One example where this approach has been applied is the 'EC Humanitarian Plus Programme' in Southern Sudan, which is an extension of ECHO's humanitarian program. The program was introduced in 2002 to build capacity and widen development cooperation in the face of protracted conflict. It was designed to address rehabilitation of health systems and services. The main goal was to promote community consultation and self reliance for primary healthcare, with grants channeled through NGOs and UN agencies. Delivery of basic services was linked to conflict analysis and peace-building in communities. The program was rolled out in two phases and was implemented over six years; this enabled agencies to adopt a more developmental way of working even during the ongoing conflict, possibly easing the transition. The new EC country agreement and introduction of development approaches have now superseded this transitional aid instrument, but it has provided many lessons on delivery of sustainable interventions and opportunities for development cooperation during protracted conflict.⁵⁷

Another innovative example of transitional aid instruments is the recent launch of the *Sudan UNDP Recovery Fund*, designed to expedite implementation of early recovery activities in Southern Sudan. This aid mechanism is perceived as a means to accelerate the delivery of essential services given the slow progression of the MDTF and includes a steering committee of government and international representatives with governance arrangements independent of the MDTF. Multi-year funds will be available, with a focus on support systems for delivery of basic services such as monitoring and evaluation and fiscal management of funds.

The World Bank's Post-conflict and Licus Trust Funds (which are being replaced by a new 'State and Peace-building' Fund) are dedicated to capacity building of government administrations based on a systems approach, while moving away from fragmented approaches that characterize crises responses.⁵⁸ The funds are intended to complement other aid instruments (e.g. MDTF) whereby technical assistance is provided to core government departments for design and management of civil service structures.⁵⁹

⁵⁶ Van Hutton W. (2007) *EC LRRD presentation*. Presented at the WHO Global Consultation on Health Recovery in Transition Situations. Montreux Dec 4-5th. 2007.

⁵⁷ Fenton, W. (2008). *Funding mechanisms in Southern Sudan; NGO perspectives*. Commissioned by Juba NGO forum.

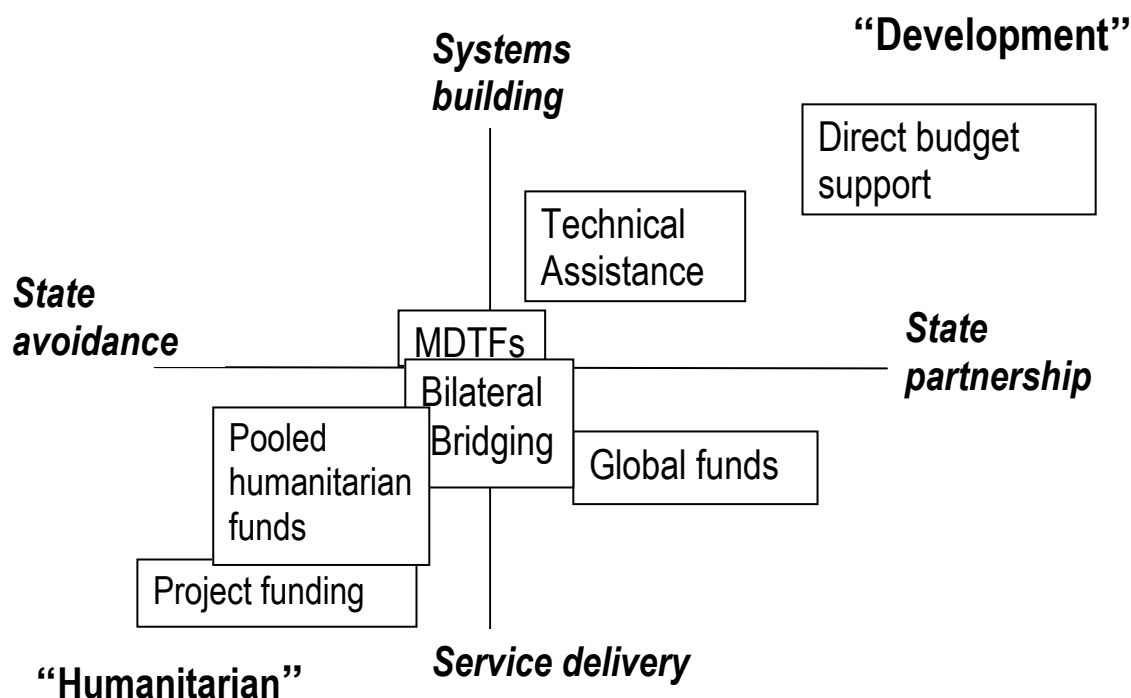
⁵⁸ ODI. [The World Bank in Fragile Situations: An issues paper](#). A report prepared for 'An Eye on the Future: the World Bank Group in a Changing World.' Amsterdam July 12-13th 2008.

⁵⁹ [World Bank](#) Accessed Aug 29, 2008.

Mix and Sequencing of Aid Instruments

Figure 9 illustrates the aid instruments described above, set along the relief to development continuum. All aid mechanisms used in the transition have their strengths and weaknesses (see Annex 6 for further details).

Figure 9: Aid Mechanisms along the relief to development continuum



This study found that the mix and sequencing of aid mechanisms influences whether funding gaps occur. The right mix of aid mechanisms can ensure both a continuation of health service delivery and support to health system strengthening. However, currently, use of aid mechanisms is often reactive. Better donor coordination at country level could actively prevent gaps in funding for service delivery.

Donors could also use their policy and operational differences to their advantage. Some donors are better positioned to fund relief for short periods of time, whereas others have a more long term commitment to the area. Some donors may be able to rapidly mobilise technical assistance, while others will have more lengthy procedures. There is thus scope for donors to discuss which donor is best positioned to support which activity, and how they can complement each other.

Countries may or may not have many donors in the health sector. If there are too few donors, there may be more risk of a transitional gap; if there are only a couple of committed donors with funds for health, harmonization may be easier and gaps may be more easily averted. Generally, it has been found that donor concentration affects not only aid volumes, but also the type and quality of aid.⁶⁰ More research on the effects of donor concentration in transitional contexts is needed.

⁶⁰ OECD (2008). [Survey of aid allocation policies and indicative forward spending plans](#). May 2008.

Overall, the emergence of new aid instruments, and the pragmatic adaptation of existing ones is encouraging and may help prevent future transitional funding gaps. More harmonized mixing and sequencing of aid mechanisms to ensure that both humanitarian and development activities are funded would also help. These changes could result in more timely and continuous disbursement of aid, increased aid flows targeted to health service delivery, and better linkages and communication between humanitarian and development funding bodies.

3.2 Donor Policy and Priorities

Donor policy and behaviour can affect whether there are transitional funding gaps. These include the limited harmonization and strategic thinking between the humanitarian and development communities, how geopolitical interests influence the amount and timeliness of aid flows, and the tension between state-avoidance and state building, which is influenced by government legitimacy and capacity.

Limited harmonization and strategic thinking

There is a need to explicitly recognize the need to continue to deliver health services, and to provide the necessary leadership to ensure that ODA, whether humanitarian or developmental, is available for this purpose during transition. More strategic, 'big-picture' thinking about continued health service coverage is therefore required by both humanitarian and development actors during transition.

There are several factors which make harmonization challenging. It takes time for development actors to set up national offices and to fully engage in a country's health sector, during which time humanitarian donors may be withdrawing. Development funders tend not to focus on immediate service delivery, as their mandate is to help the government organize this. They also differ from the humanitarian community in terms of their mindset, organizational culture, planning, administration and funding arrangements (for example, they work with much longer timeframes). Focused discussions on how to continue to provide existing health services are therefore required until other strategies (government or NGO provision or contracting-out) are put in place. Such planning was often not done in the case study countries due to a lack of donor or government ownership and/or capacity during the transition process. In addition, donors with humanitarian and development arms within the same organization (such as ECHO and the EC; and USAID and OFDA) acknowledge that more needs to be done to stimulate the internal transfer of strategic knowledge between them, and to overcome bureaucratic obstacles to cooperation.

These challenges also point to the need for better information collection on funding, coverage and timeframes for withdrawal of humanitarian actors. Information is often difficult to obtain as few donors have in-country sector specialists to interface directly with the government health sector counterparts and NGOs. Most donors undertake periodic evaluations and multi sector reviews by independent evaluation teams, but these are focused on specific projects or donors, and do not make ongoing assessments of the funding, coverage and

status of primary and secondary health service delivery and funding in a country, nor is there often much support for the MoH to carry this out.

Finally, NGOs can be influential in terms of contributing to strategic thinking, highlighting upcoming funding gaps (as they did in Liberia), and mobilizing resources to fill them. NGOs representatives highlighted their organizational flexibility in temporary reallocation of resources where anticipated gaps or project closure was imminent. Nevertheless, NGOs faced closure at both primary and secondary healthcare levels in DRC and Southern Sudan due to marked shortfalls in humanitarian funds or major delays in donor disbursements. This resulted in large gaps in service delivery where the government did not have the resources for funding of the health facilities. NGOs with access to unrestricted private funds, such as MSF, can leave service delivery gaps when they depart which are sometimes left unfilled due to absence of a negotiated exit strategy, and lack of capacity and funding for government or other NGOs to support the programs.

Geopolitical interests

The geopolitical interests of donor governments are important, especially in regions where regional security and stabilization efforts are a primary concern. Donor policy documents are often explicit about which countries are of strategic interest, and receive support. If geopolitical interests supersede concerns about weak governance, donors are more likely to engage in early post-conflict. This is likely to be one reason why development aid was quickly available to replace humanitarian aid in Afghanistan and Timor Leste.

Global aid flow tracking has identified resulting 'aid orphans' and 'aid darlings'. A recent OECD-DAC report found that "75 percent of ODA for 38 fragile states benefited just five countries in 2006: Afghanistan, Sudan, DRC, Haiti and Cambodia," and half of this was debt relief.⁶¹

One study which analysed data from 1992-2002 found a few 'aid darlings' (mostly post-conflict countries, including Cambodia, Laos, Papua New Guinea and Sierra Leone) and many 'aid orphans,' (for example, Burundi, the Democratic Republic of Congo, Nigeria and Sudan).⁶² It also found that after 9/11, donors paid more attention to certain countries, namely Iraq and Afghanistan, but continued to underfund the 'aid orphans'. It argued that this was due,

"in part because the costs of state failure within them was not of sufficient consequence to the international community or to particular donors to justify larger aid amounts. This in part was reflected by a lack of diplomatic engagement, and was made worse by a lack of media attention in many fragile states."⁶³

⁶¹ OECD-DAC. 2007. [*Ensuring fragile states are not left behind*](#). A Fact Sheet. Dec.

⁶² Dollar D and V Levin. 2005. 'The Forgotten States: aid volumes and volatility in difficult partnership countries (1992-2002).' Summary paper prepared for DAC Learning and Advisory Process on difficult partnerships. <http://www.oecd.org/dataoecd/32/44/34687926.pdf>

⁶³ McGillivray M. 2003. Aid effectiveness and selectivity: integrating multiple objectives in aid allocations. *DAC Journal* 4(3):23-36.

Geopolitical interests which influence funding flows in early post-conflict can thus exacerbate or alleviate transitional funding gaps.

Tensions between state-avoidance and state-building

At the heart of the transition from relief to development is a political question, which is when and how donors choose to engage with a country's nascent government. Donors are generally risk averse, restricting direct contributions to governments due to fiduciary risk and governance concerns. They tend to direct funds outside government systems ('off-budget'), channelling funds to NGOs, UN agencies and private providers to increase transparency and accountability. Concerns about the capacity of the state to deliver services also affect donor policy and behaviour.

Major institutional gaps include lack of policies, fragmented budgets and weak sector organization and domestic accountability with associated corruption. With limited state level capacity, alignment is difficult and development donors tend to state-avoid until state systems are put in place. On the other hand, state-building approaches have been tested in early post-conflict with some success. In Timor Leste, sector-wide support met with significant success at the early stages of the transition due to strong leadership by both government and international agencies, and a combined UN/WB head of health whom spearheaded the approach. In DRC and Sierra Leone, there is a recognition that the solution to fragmentation lies in the development of a framework, and strengthening government systems to assume fund management and implementation responsibilities.

National health plans are vital in stimulating harmonised engagement of all sector stakeholders. In Liberia, their creation enabled the development community to engage, allowing agencies to agree on priorities for the health sector, and to develop a budget and strategy to meet them. In Afghanistan and Southern Sudan, national health plans were produced with priority given to delivery of a basic package of health services through contracting-out, which served as a clear mechanism to channel donor investment, and helped to align and harmonize donors. On the other hand, in DRC coordination efforts and planning documents have not been able to resolve short funding cycles, unpredictable funding, limited consolidation of the budget across donors, and weak links to expenditure of government revenue for the health sector. The inability of planning processes to address these issues may be explained by lack of trust in government capacity, and the continuing conflict in the east of the country.

Some post-conflict governments decentralize operational autonomy to the periphery while central levels retain governance, stewardship and policy functions. This poses additional challenges in terms of capacity as illustrated in Southern Sudan, Sierra Leone and Liberia, where challenges include problems with transfer of funds to the periphery due to weak financial systems. This is exacerbated by severe human resource gaps, made worse by hiring of skilled local personnel by NGOs and UN agencies, which means that agencies have very few national counterparts to collaborate with.

3.3 Impact on Predictability

All of the above factors – nature of the aid instruments, donor policy and governance issues – impact on aid predictability.⁶⁴ Lack of understanding of which aid mechanisms work, poor sequencing of aid flows with abrupt cessation of funds, inconsistent allocation criteria used by donors, discrepancies between committed and disbursed funds, disbursement delays, non-compliance with agreed conditionality, and governance issues in recipient countries all affect aid volatility. For example, aid volatility in the health sector in Southern Sudan is exacerbated by use of aid instruments that are insufficiently adapted to transitional contexts. In DRC, the abrupt withdrawal of humanitarian funds, together with parallel delays in development funds and recurrent cessation of development funding, has led to a major service vacuum in selected health zones. In Liberia, health only received 13% of what was requested in the 2006 consolidated appeal and 29% in 2007.⁶⁵

This study argues that an additional reason for aid volatility in transition is a lack of aid tracking. Humanitarian donors and agencies can find it difficult to advocate for immediate service delivery because it is difficult to obtain an overview of the extent of humanitarian health services, funding flows and timelines for withdrawal. There is no humanitarian agency that has the mandate to collect this information. The humanitarian health clusters could take on this role, however, to date, no health cluster had done so. Ministries of Health should collect this type of information, but little evidence was found that many have done so.

The benefits of aid tracking can be shown by the experience of Liberia, which was the only case country conducting continuous tracking of aid flows to the health sector. Donors and Liberian government officials noted that this has been very beneficial as tracking has explicitly revealed the short term nature of projected aid flows, which has allowed the MoHSW to lobby donors to make more sustainable commitments, and has facilitated budgeting for the development of the health sector.

4. FURTHER RESEARCH AND CONCLUSIONS

4.1 Proposed Research Agenda

One of the aims of this study was to identify key research areas concerning the question of transitional funding and aid effectiveness during the transition of relief to development in post-conflict countries. Based on the findings of this study, a number of areas have been raised which require more in-depth research around the transitional funding gap:

⁶⁴ This is supported by the findings in McGillvary, M. (2006) *Aid allocation in fragile states*. UNU Wider discussion paper; Bilir, A. Hamann, A.J. (2005) *Volatility of development aid, from the frying pan into the fire*. IMF working paper; and Williams, G. Hay, R. (2007). *Fiscal Space and sustainability from the perspective of the health sector*. A paper for the High Level Forum on the Health MDGs.

⁶⁵ United Nations (2008) *Critical Humanitarian Gaps in Liberia*.

- Explore suitable methods to ensure accurate in-country information on aid flows to foster improved planning of the transition from relief to development. Examine why existing financial tracking services remain under-utilized, and how lack of data impacts (or not) on decision-makers.
- Study the impacts of funding gaps and volatile funding on health services (primary and secondary) and health outcomes.
- Conduct a comparative study on the adaptation of existing mechanisms that bridge the divide between humanitarian and development ODA.
- Conduct in-country studies in Sierra Leone and DRC to determine whether transitional gaps occurred, and the reasons for these (for example, does lack of policy lead to lack of development aid, or *vice versa*).

Finally, much more study is needed on overall aid effectiveness in transitional settings and the approaches used to rebuild health systems. Such studies would help shed light on which types of approaches yield best results, both in terms of both immediate and long-term basic service delivery and institutional capacity building. It is also important to investigate current attempts to monitor the impact of aid and its effectiveness in transitional settings as this study found limited evidence of this in the countries studied.

4.2 Conclusions

One of the major challenges during the transition from humanitarian to development aid is maintaining existing levels of health services, and preventing a reduction in services when populations are still very vulnerable. Some of the determinants of the transitional gap, such as the nature, mix and sequencing of aid mechanisms, and certain aspects of donor behaviour, such as leadership, harmonization, use of TA, and aid predictability, can be addressed through better technical practice. More aid tracking would also help, in terms of making explicit current and expected funding flows for health services over time. This information, combined with knowledge about coverage of health services, would be a powerful tool for nascent Ministries of Health, NGO and UN agencies to lobby for more predictable aid.

Other determinants of the transitional funding gap, such as weak governance, tendency for risk aversion, and the weak political will to engage in some contexts, are more difficult to tackle. Whilst donors recognise the need be more supportive of the state, and to shift to budget (sector) support to assist in legitimising a nascent government, donors are reluctant to commit funds where the financial and administration systems are weak. In most cases, donors appear to continue to be risk averse and hesitate to commit to general or sector budget support. There are, however, exceptions as shown by Timor Leste and Sierra Leone.

Improving transitional funding, and delivery of aid to fragile states more generally, is now on the donor agenda, as evidenced by the OECD-DAC's Principles of Engagement in Fragile States, and the Good Humanitarian Donorship Initiative, both of which highlight the importance of more predictable and long-term aid. The recent Kinshasa statement on Fragile States, prepared for the September 2008

Accra Agenda on Action, pledges its signatories to develop more flexible and rapid funding mechanisms in transition, and to ensure more timely availability of funding.

Given these recent initiatives on aid effectiveness, there is a possibility that transitional funding gaps will be alleviated in the future. It is important to overcome transitional funding gaps, both for the health of the populations involved, and to assist with the broader goals of state-building, where delivery of basic services such as health are integral to the social compact between a state and society.

BIBLIOGRAPHY

Agha, Z. Williamson, T. 2008. Common funds for sector support. ODI Briefing paper.

Bornemisza, O. Sondorp, E. 2002. Health Policy formulation in complex Political Emergencies and post-conflict countries. London School of Hygiene and Tropical Medicine.

Carlson, C. 2004. Evaluation of Global fund in Sierra Leone. HLSP London, UK.

Capobianco, E, Naidu, V. 2007. A review of health sector aid financing to Somalia (2000-2006), World Bank.

Cordella, T. Dell'Ariccia, G. 2003. Budget Support Versus Project Aid. IMF Working Paper No. 03/88, Washington: International Monetary Fund.

Development Financing Team. 2005. Improving the allocation of aid among countries: what can DFID do? DFID. London.

Eifert, B. Gelb, A. 2005. Improving the Dynamics of Aid: Towards More Predictable Budget Support. Policy Research Working Paper No. 3732. Washington: World Bank.

Fenton, W. 2007b Treading a Delicate Path: NGOs in Fragile States. Case study Southern Sudan. Save the Children, London

Fenton, W. Funding Mechanisms in Southern Sudan: NGO Perspectives. Draft January 29 2008. Juba NGO Forum

Foster, M. Killick, T. 2006. What Would Doubling Aid do for Macroeconomic Management in Africa? Working Paper 264. ODI. London.

Graves, S. Wheeler, V. 2006. Good Humanitarian Donor ship: overcoming obstacles to improved collective donor performance. ODI HPG Paper.

High-Level Forum on the Health MDG's. 2005. Health in Fragile States: An Overview Note

High-Level Forum on the Health MDG's. 2005. Health Service Delivery in Post-Conflict States

Harmer, A. Stoddard, A. 2006. A. Review of GHD domestic strategies. ODI HPG paper.

International Development Association. 2007. Aid architecture: an overview of the main trends in official development assistance flows. IDA.

Lane, C. Glassman, A. 2007. Bigger And Better? Scaling Up And Innovation In Health Aid – Despite progress, much can still be done to improve the efficiency of aid to achieve better health outcomes. Health Affairs. 26(4): 935-948.

Leader, N. Colenso, P. 2005. Aid Instruments in Fragile states. PRDE Working paper 5.

LRRD. 2007, A framework for linking relief to development. EC PowerPoint presentation.

Manning, R. 2006. Will 'Emerging Donors' Change the Face of International Co-operation? Development Policy Review. 24 (4).

McGillvary, M. 2004. Descriptive and Prescriptive analysis of aid allocation. UNU Wider paper.

McGillvary, M. 2006. Aid allocation and fragile states. UNU WIDER discussion paper

Macrae, J and Harmer, A. 2004. Beyond the continuum: and overview of the changing role of aid policy in protracted crises. In J Macrae and A Harmer (eds) HPG report 18, beyond the continuum, the changing role of aid in protracted crises. ODI London.

Merlin/LSHTM. 2007. Health service delivery in fragile states: \$5 myth or reality. Conference proceedings. London, Merlin.

Mowjee, T. 2006. Review of OCHA Emergency Response Funds.

Msuya, C. Sondorp, E. 2005. Interagency Health Evaluation Liberia, September 2005, final report. IHA

Newbrander, W. 2005. Rebuilding health systems and providing health services in fragile states

OECD, DAC. 2005. Senior level forum on Development effectiveness in Fragile States; Aid allocation and criteria.

OECD, DAC. 2005. Principles of Good International Engagement in Fragile States.

OECD DAC ODA Creditor Reporting System (CRS), health sector aid disbursement reported by donor.

OECD. 2007. Ensuring Fragile States are Not Left Behind. Fact Sheet 2007.

OECD DAC. 2005. Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results, and Mutual Accountability. DCD/DAC/EFF. Paris: Organization for Economic Cooperation and Development.

Oxfam. 2007. The UN Central Emergency Response Fund one year on. <http://ochaonline.un.org/cerf/CERFanditsPartners/CERFandNGOs/tabid/1825/Default.aspx> accessed 25 March 2008

Palmer, N. Strong, L. Wali, A. Sondorp, E. 2006. Contracting out health services in fragile states. *BMJ* 2006; 332; 718-721

Randel, J *et al.* 2005. Financing countries in protracted humanitarian crises; an overview of new instruments and existing aid flows. (In MacRae *et al* (2005), HPG Report No 18. Beyond the continuum, the changing role of aid in crises. ODI).

Refugees International. South Sudan: Key facts on funding recovery needs. <http://www.reliefweb.int/rw/RWB.NSF/db900SID/KHII-7CG4K5?OpenDocument> accessed March 26 2008

Sabri, B., Siddiqi, S., Ahmed, A.M., Kakar, F.K., Perrot, J., Towards sustainable delivery of health services in Afghanistan: options for the future, *Bulletin of the World Health Organization* 2007; 85:712–718

Save the Children. Save the Children's Experience with CERF in 2007, <http://ochaonline.un.org/cerf/CERFanditsPartners/CERFandNGOs/tabid/1825/Default.aspx> accessed 25 March 2008

Scanteam Norway. Review of post-crisis multi-donor trust funds, 2007. WB and NORAD in cooperation with CIDA, Netherlands Ministry of Foreign Affairs and DFID, 2007. <http://www.worldbank.org/rmc/cofdr/MDTFReportExecSum.pdf>

Shiavo-Campo, S. 2003. Financing and Aid Management Arrangements in Post-Conflict Situations. CPR Working Papers No. 6

Shuey, D.A. Qosaj, F.A. Schouten, E.J. Zwi, A.B. 2003. 'Planning for health sector reform in post-conflict situations: Kosovo 1999-2000' - *Health Policy* 63 -2003

Sondorp, E. Bornemisza, O. 2007. Inter-agency Health and Nutrition Evaluation Initiative Follow-up Mission to Liberia, December 2006. A Report for the Inter-agency Health Evaluations Initiative.

Stoddard, A. Salomons, D. Havers, K. Harmer, A. 2006. Common Funds for Humanitarian Action in Sudan and the Democratic Republic of the Congo: Monitoring and Evaluation Study. Center on International Cooperation, New York University in collaboration with the HPG ODI.

Surke, A. Ofstad, A. 2005. Filling "the Gap": Lessons Well Learnt by the Multilateral Aid. CMI Working Papers.

Taylor, L. 2005. Absorptive capacity of health systems in fragile states. Technical approach paper HLSP.

Travis, P. Bennet, S. Haines, A. Pang, T. Bhutta, Z.Q. Hyder, A.A. *et al.* 2004. Overcoming Health Systems Constraints to Achieve the Millennium Development Goals. *Lancet* 364: 900–6.

Tulloch, J. Saadah, F. de Araujo, R.M. de Jesus, R.P. Lobo, S. Hemming, I. Nassim, J. and Morris, I. 2003. Initial Steps in Rebuilding the Health Sector in East Timor. National Academic Press

UNDP. 2008. Guidance note on early recovery. Cluster Working Group on Early Recovery, in cooperation with the undg-echha Working Group on Transition.

Waldman, R. 2003. Rebuilding health services after conflict: lessons from east Timor and Afghanistan. ODI

Waldman, R. 2006. Health Programming in Post-Conflict Fragile States. Arlington, Virginia, USA: Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID).

Walker, P. Pepper, K. 2007. Follow the money; a review and analysis of the state of humanitarian funding, Feinstein International Centre.

Waters, H. Garrett, B. Burnham, G. 2007. Rehabilitating health systems in post-conflict situations - UNU WIDER Research Paper No. 2007/06

World Bank. 2004. The Millennium Development Goals for Health: Rising to the challenges.

World Bank Afghanistan Reconstruction Trust Fund
<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/SOUTHASIAEXT/0,,contentMDK:21634490~pagePK:146736~piPK:146830~theSitePK:223547,00.html>
accessed 19 March 2008.

World Bank. 2008. Chapter for Public Expenditure Review Health Sector in DRC.

Zwi, AB. Martins, K. Grove, N.J. Wayte, K. Martins, N. Kelly, P. 2007. Timor-Leste Health Sector Resilience Study and Performance in a Time of Instability. Sydney: the University of New South Wales.

[http://www.reliefweb.int/rw/lib.nsf/db900sid/OCHA-776V2V/\\$file/UNSW_oct2007.pdf?openelement](http://www.reliefweb.int/rw/lib.nsf/db900sid/OCHA-776V2V/$file/UNSW_oct2007.pdf?openelement) accessed 19 March 2008.

ANNEX 1 – TERMS OF REFERENCE

Health and Fragile States Network

Terms of Reference for a Paper on The Health Sector and the Transitional Policy and Funding Gap: A Question of Aid Effectiveness

Introduction

Fragile states face many challenges with respect to the provision of effective basic services. One particular challenge is the structure and functioning of current aid systems. Fragile states tend to receive less aid *per capita* than other low-income countries due to the various factors involved in making aid effective in these environments. The aid they do receive is disproportionately volatile over time compared with other aid contexts.

Fragile states in the transition from conflict to peace face particular difficulties with funding (the so-called transitional funding gap). Humanitarian funding for health and other basic services is often withdrawn after a country is judged to be at peace (or no longer at risk of active conflict), with the expectation that development funding will replace and supplement humanitarian funding. However, it often takes several years for development funding mechanisms to be put in place. This delay frequently impacts on health service providers, whom have to cope with decreasing levels of humanitarian aid in situations where health indicators are still extremely poor.

The development of an evidence base about the nature and extent of the transitional funding gap with respect to the health sector is important for addressing the challenge of providing more and better aid during transitional periods in fragile states. Relatively little work has been done on the transitional funding gap, although it has been mentioned in some studies of the humanitarian aid system (Leader and Colenso 2005; Harmer and Macrae, 2004; Macrae 2001, Macrae 2002; OECD-DAC 2006; Schiavo-Campo 2003; Willitts-King 2006). It has recently been highlighted as an issue requiring attention by the Good Humanitarian Donorship initiative⁶⁶ (Graves and Wheeler, 2006) as well as by the WHO Health and Transition Consultation Workshop, Montreux Dec 4-6th 2007. More could be done to document experiences in the field with respect to the aid mechanisms being used by different donors, reasons for funding constraints, and effects on health services and health outcomes in populations affected by conflict. The Health and Fragile States Network is commissioning a paper on this topic, the first in a series of discussion papers.

⁶⁶ <http://www.goodhumanitariananddonorship.org/> GHD Principle 9. Provide humanitarian assistance in ways that are supportive of recovery and long-term development, striving to ensure support, where appropriate, to the maintenance and return of sustainable livelihoods and transitions from humanitarian relief to recovery and development activities.

Health and Fragile States Network

The Health and Fragile States Network was constituted in June 2007 during a meeting at DFID on health and fragile states. The Network's purpose is to take forward work initiated by the High Level Forum on the Health MDGs (2004-5) and the OECD-DAC Fragile States Group's work-stream on Service Delivery (2005-2006). These initiatives created the momentum for bringing together a network of policymakers, practitioners and researchers to build consensus on effective policy and practice on health in fragile states.

Objectives of the Network

- Foster dialogue and debate, raise awareness and advocate for best practice on a variety of different issues related to health in fragile states.
- Inform and influence policy issues related to health in fragile states.
- Identify research topics, elicit funding for research and commission research in order to strengthen the evidence base for operational practice and inform the policy debate.
- Improve knowledge management by documenting and widely disseminating lessons learned.
- Provide greater visibility to some of the complex aspects related to health services in fragile states in order to promote more and better aid for the sector.
- Encourage linkages between health and broad governance issues, and promote links to other sectors such as education and livelihoods.

The Network is open to participation by individual practitioners and representatives from the many institutions, agencies and service providers (state and non-state) that are involved in research, finance or delivery of health and/or governance programmes and services in fragile states. Network members are represented through a Steering Committee. A Secretariat, based at LSHTM, manages the Network's activities. The Network aims to ensure that it links to relevant existing forums and initiatives, and a mapping exercise is ongoing to identify links and priorities in these relationships.

Focus of the Health and Transition Paper

Key questions for the health and transition paper to address include:

1. What is the nature of the transitional funding gap? What is the extent of the funding gap - how often does it occur and how large is it estimated to be in countries that experience it? (20% of paper)
2. Why does the transition gap exist? What are the key issues (donor and multilateral aid mechanisms and policies, funding flows, lack of planning, etc)? How does funding modality (e.g. humanitarian or developmental; multilateral or bilateral mechanisms) impact on how NGO and UN agencies operate (i.e. sometimes it is not total amounts, but the type of funding and the way its channelled that affects health service delivery)? What is being done by the donors to close the transition gap in terms of new or adapted

mechanisms, changes in funding flows, policy initiatives and principles, and others means? What is the impact of the departure of health actors with substantial self-funded budgets? What are the political aspects of the transition gap and how can they be influenced? (30% of paper)

3. Is the health sector particularly affected by this funding gap? What are the effects of the transition gap on coverage and nature of health services during transitional periods? What is the effect on longer term health services, and the reconstruction of the health system? Are there any cases where it has been perceived to impact on 'state-building processes'? (30% of paper)
4. What can be said about the impact on health outcomes; i.e. what are estimates in terms of impact on health services and subsequent impact on health outcomes? (10% of paper)
5. Conclusions about the nature of the transitional gap, impact on health services and health outcomes, and what can be done about it (10% of paper).

Methods and Timeline

The work for this consultancy will be completed between January and March, with an approved final report due at the end of March 2008. The Terms of Reference (ToR) will be sent to a range of prospective consultants with an application deadline of 6 pm GMT, Wednesday January 9th. To apply, the consultant(s) should submit a two page plan of work, along with a draft budget to olga.bornemisza@lshtm.ac.uk, copied to egbert.sondorp@lshtm.ac.uk. The study elements should include a literature review, more than 10 interviews with headquarters NGO, UN and donor staff, several case studies, and short field visits to at least two countries to expand on specific case studies. Case studies should be countries that have experienced a transitional funding gap, and could include DRC, Sudan and Burundi (where GHD pilots have taken/are taking place)⁶⁷, countries where there is an IASC Health Cluster,⁶⁸ or countries where innovative aid mechanisms are being tried (Zimbabwe). These could be compared to countries where there are no strong coordination efforts. The rationale for choosing certain countries should be explained. Efforts should be made to ensure that a variety of key donors (i.e. EC/ECHO, USAID, DFID, Norway) are included in the range of documented experience. Once the consultant is chosen by the Steering Committee, they will be asked to prepare a more detailed plan of action in the first two weeks of the consultancy, in collaboration with the Network Secretariat and Steering Committee. There will be a mid-term meeting in February 2008 between the consultant, Secretariat and selected members of the Steering Committee to monitor the progress of the project.

Applications to do both ToRs (this one, plus the ToR for a paper on health and statebuilding), are welcome either by firms or groups of individuals. Please briefly explain the comparative advantage gained by bidding for both. Consultants may

⁶⁷ <http://www.goodhumanitariananddonorship.org/pilots.asp>

⁶⁸ <http://www.humanitarianreform.org/> . For a list of countries see: <http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/clusters%20pages/health%20cluster/Presentation%20Health%20Cluster%20August%202007.ppt#11>

also apply for a single ToR, but they may be asked to communicate and collaborate with the consultants working on the other ToR.

Links to various policy initiatives

This paper will build on the WHO HAC Montreux meeting, Dec 4-6 2007, contributing to further development of frameworks and analysis about transitional issues. The background papers to this conference, power-points and the final conference proceedings will be sent to the consultant at the beginning of the consultancy.

The paper may also feed into the OECD-DAC's 'Health as a Tracer Sector' work being done in preparation for the Accra High Level Forum on Aid Effectiveness in Sept 2008. This work will focus on four areas: developing the evidence-base on aid effectiveness; identifying donor constraints for providing long-term sustainable financing in health; strengthening the link between aid effectiveness and health systems development; and strengthening global accountability mechanisms. Our paper will touch on the first three areas of work. It will also inform more broadly the new International Health Partnership, which has a focus on scaling up health services and improved aid effectiveness to meet the health MDGs.⁶⁹ Finally, it will be widely distributed to donors, UN agencies and NGOs in order to inform policy.

Expected Outputs

- A detailed plan of action not later than two weeks from the start of the work. Methods used should be robust enough to allow for the possibility of a peer-reviewed paper to be published, based on the final report.
- A short briefing note (2-3 pages) on progress and results to date, submitted in February 2008 for the monitoring meeting in London.
- A final draft report of no more than 30 pages, plus a 4-5 page executive summary (in the style of an ODI HPG briefing paper), plus a concise set of powerpoint slides highlighting the main findings and conclusions. These are to be submitted to the Secretariat by Monday, March 17, 2008. The Steering Committee will comment on them and give feedback to the consultant(s) by Monday, March 24th.
- The final document should be completed by Monday, March 31st.

Budget

The proposed budget should reflect the scope of the outputs expected, and include consultancy fees, per diems, travel, insurance and other expenses. An advance of 50% of the agreed budget will be paid as soon as the contract has been signed, with the remainder being paid after satisfactory completion of the task.

⁶⁹ <http://www.who.int/healthsystems/ihp/en/index.html>

Literature

Graves S and V Wheeler. 2006. *Good Humanitarian Donorship: overcoming barriers to improved collective donor performance*. ODI Discussion paper. London:ODI.

http://www.odi.org.uk/hpg/papers/discussion_GHD.pdf

Harmer A and J Macrae ed. 2004. *Beyond the continuum: the changing role of aid policy in protracted crises*. ODI HPG Research Report. London: ODI.

<http://www.odi.org.uk/HPG/papers/HPGbrief16.pdf>

Leader N and P Colenso, 2005. *Aid Instruments in Fragile States*. DFID Poverty Reduction in Difficult Environments (PRDE) Working Paper 5.

<http://www.dfid.gov.uk/pubs/files/fragile-states/aid-instruments.pdf>

Macrae J. 2001. *Aiding Recovery?: The Crisis of Aid in Chronic Political Emergencies*. London: Palgrave Macmillan.

Macrae J.2002. *The New Humanitarianisms: A review of trends in global humanitarian action*. ODI HPG Report. London: ODI.

<http://www.odi.org.uk/HPG/papers/hpgreport11.pdf>

OECD-DAC. 2006. Humanitarian Aid in DAC peer reviews: a synthesis of findings and experiences 2004-2005.

http://www.goodhumanitariananddonorship.org/DAC_SYNTHESIS_ENG_DECLASS.pdf

<http://www.goodhumanitariananddonorship.org/dac-peer-reviews.asp>

Schiavo-Campo S. 2003. Financing and Aid Management Arrangements in Post-Conflict Situations. CPR Working Papers. Paper No. 6. June. Social Development Department, Environmentally and Socially Sustainable Development Network.

[http://lnweb18.worldbank.org/ESSD/sdvext.nsf/67ByDocName/FinancingandAidManagementArrangementsinPost-ConflictSituations/\\$FILE/WP6June18.pdf](http://lnweb18.worldbank.org/ESSD/sdvext.nsf/67ByDocName/FinancingandAidManagementArrangementsinPost-ConflictSituations/$FILE/WP6June18.pdf)

Willitts-King B. 2006. Briefing paper on donor financing decisions in EU humanitarian aid. Commissioned by the Ministry for Foreign Affairs of Finland. Revised report 12 December 2006.

[http://www.goodhumanitariananddonorship.org/Barnaby%20Willitts-](http://www.goodhumanitariananddonorship.org/Barnaby%20Willitts-King%20briefing%20paper%20on%20donor%20financing%20decisions%2012%20Dec%202006.doc)

[King%20briefing%20paper%20on%20donor%20financing%20decisions%2012%20Dec%202006.doc](http://www.goodhumanitariananddonorship.org/Barnaby%20Willitts-King%20briefing%20paper%20on%20donor%20financing%20decisions%2012%20Dec%202006.doc)

ANNEX 2 - SEMI-STRUCTURED INTERVIEW GUIDES: DONORS AND UN AGENCIES

1. Health sector aid during transition from relief to development
 - a. What aid mechanisms are used for the health sector during periods of transition?
 - b. What are the reasons to deploy certain mechanisms, or not in transition situations?
 - c. Are other donors included in deliberations about potential aid mechanisms?
 - d. Who do you see as the driver of change of this process within the countries? What about its sustainability?
2. Implementing partners
 - a. Are national authorities included in deliberations about potential aid mechanisms?
 - b. Does the presence of potential partners affect the selection of aid mechanism?
 - c. Are (potential) partners included in deliberations about potential aid mechanisms?
3. Disbursement/channelling mechanisms
 - d. How is aid disbursed to the health sector during transition? e.g. sector support, shadow budgeting, pooled funding, earmarked budgeting?
 - e. Why were these mechanisms deployed?
 - f. What about its timeliness, predictability, alignment?
4. Obstacles to/ gaps in funding
 - a. Are there any obstacles to funding? Have there been gaps or delays?
 - b. Why did this gap/delay occur? (e.g. political, administrative)
 - c. What impact did these (perceived) gaps have on health programming, service delivery, or health outcomes? Please describe, including evidence and how the impact can be measured.
5. Resource allocation
 - a. Which kind of health services are prioritised during the transition: e.g. PHC, vertical programs, institutional capacity building.
 - b. How is this prioritisation determined? By whom? At what time is this decided? E.g. during, post-conflict, etc.
6. Aid effectiveness
 - a. Can you give examples of where selected mechanisms did work or in fact did not work? (preferably in our selected countries) Please explain it worked or failed.
 - b. How is effectiveness measured? (e.g. are there indicators for monitoring and evaluation of the health sector funding mechanism? Is there financial tracking of donor resources)
 - c. Have evaluations been conducted or are they planned? If so, can we receive copies of reports
7. Improving transitional funding to the health sector
 - a. In your opinion, how could health services/health programming best be financed during the transition from humanitarian support to developmental support?
 - b. What would be the most effective coordination mechanism to ensure transition from relief to development? Can you give positive and negative examples? Please explain the reasons for its success or failure.

ANNEX 3 - SEMI-STRUCTURED INTERVIEW GUIDE: NGOs AND MOH

1. Health sector aid during transition from relief to development
 - e. What sources of funding are accessible for your health programming during periods of transition?
 - f. Are there reasons to prefer certain mechanisms, or not in transition situations?
 - g. Are implementing partners like yourselves included in deliberations about potential aid mechanisms?
2. Obstacles to/ gaps in funding
 - d. Are there any obstacles to funding? Have there been gaps or delays? (predictability & planning)
 - e. Why did this gap/delay occur? (e.g. donor, political, administrative)
 - f. What impact did these (perceived) gaps have on health programming, service delivery, or health outcomes? Please describe, including evidence and how the impact can be measured.
3. Resource allocation
 - c. Which kind of health services are prioritised during the transition: e.g. PHC, vertical programs, institutional capacity building.
 - d. How is this prioritisation determined? By whom? At what time is this decided? E.g. during, post-conflict, etc.
4. Aid effectiveness
 - d. Can you give examples of where selected funding mechanisms did work or in fact did not work? (preferably in our selected countries) Please explain it worked or failed.
 - e. How is effectiveness measured by your organization? (e.g. Are there indicators for monitoring and evaluation of the health sector funding mechanism? Is there financial tracking of donor resources)
 - f. Have evaluations been conducted or are they planned by your donors? If so, can we receive copies of reports
5. Improving transitional funding to the health sector
 - c. In your opinion, how could health services/health programming best be financed during the transition from humanitarian support to developmental support?
 - d. What would be the most effective coordination mechanism to ensure transition from relief to development? Can you give positive and negative examples? Please explain the reasons for its success or failure.

ANNEX 4 - KEY INFORMANT CONTACT LIST

UN and Multilateral Agencies	
LOPEZ ACUNA, Daniel	Director, Recovery and Transition Programmes, HAC/REC
PAOLO. Piva	Advisor. Department for Health System Governance and Service Delivery (HDS)
LERBERGHE VAN. Wim	Department for Health System Governance and Service Delivery (HDS)
BAILEY, Laura	WB. Head, Senior Operations Specialist. FS Unit
NANDY, Robin	Senior Advisor, Health in Emergencies, UNICEF. New York
STAHL, Gary	Director of Resource Mobilization
ESHAYA-CHAVIN, Bruce	Head, Health and Care Department, IFRC
SPIEGEL, Paul	Director of Health, UNHCR (Geneva)
GRIEKSPoor, Andre	PME, WHO Geneva.
INGOs	
DOULL, Linda	Health and Policy Director, Merlin, UK.
CADGE, Nicola	Health Adviser, Fragile States, Save UK.
MEDWAY, Peter	Director of Operations, International Medical Corps (IMC)
MORGAN, Sarah	Director of Humanitarian Affairs. WVI Geneva.
TEKLU, Mesfin	Africa Regional Health Director. WVI.
PHILLIPS, Mit	Head of Health, MSF Belgium
DONORS	
BLAIS, Pierre	Counsellor/Permanent Mission. Canada
PAPOWITZ, Heather	USAID/OFDA PH Specialist
LEADER, Nick	DFID Team Leader Nepal/former DFID UK FS
MEYER, Johan Kristian	Representative of Norway Humanitarian Dept
GERRITSEN, Marco	DGIS Fragile States focal person/Health
HEFFINCK, Johan	Senior Expert, Sector Policies, Nairobi
VAN HATTUM, Walter	Policy Coordinator – ECHO Recovery/Transition

TULLOCH, Jim	AusAID Health Sector Director
VIISAINEN, Kirsi	Team Leader for Grants Support. Global Fund. Geneva.
INDEPENDENT EXPERTS/INSTITUTES	
WALDMAN, Ron	Avian and Pandemic Influenza Response Unit Team Leader, USAID
PAVIGNIANI, Enrico	Health Systems consultant
MACRAE, Joanna	Former DFID CHASE (freelance)
Democratic Republic of the Congo (DRC)	
COOPER, Ros	Human Development Advisor, DFID DRC
AFGHANISTAN	
NAEEM, Ahmad J	Head, Grants and Contract Management Unit, Ministry of Public Health, Afghanistan
RWANDA	
FRITSCHKE, Gyuri	Management Sciences for Health. Rwanda. (former WB Afghanistan, S Sudan)
S. SUDAN	
HERRING, Bengt	Health Sector Advisor, Joint Donor Office, Juba.
SIERRA LEONE	
REID, Joanna	DFID Deputy Head of Office & Senior Regional Health Adviser, West Africa
KOSOVO	
REINICKE, Matthias	Programme Manager, Operations Unit/Health European Agency for Reconstruction
TIMOR LESTE	
JOHNSTON, Tim	Health team leader for Timor-Leste

ANNEX 5 - LIBERIA CASE STUDY

1. The Context

1.1 Social & Political Environment

After fourteen years of fighting, the conflict in Liberia finally ended in 2003. A National Transitional Government of Liberia presided over the successful disarmament and demobilisation of combatants in 2004 and general elections the following year. President Ellen Johnson-Sirleaf was elected in November 2005 with 59% of the presidential vote, in elections that most Liberians considered fair, and has made significant progress restoring public confidence.⁷⁰

Despite numerous challenges, Liberia has reached important milestones for the relief of international debt, renegotiated major concession agreements, and developed a comprehensive, interim poverty reduction strategy. A three year poverty reduction strategy will be implemented from mid-2008, throughout which fees for basic social services such as primary education and healthcare will continue to be suspended.

Although reliable household information remains scarce, estimates continue to indicate that over half the population of 3,200,000 live on less than \$1 a day, with a majority of people living in Monrovia and unemployment hovering near 80%.⁷¹ Major challenges that lay ahead include maintaining peace and security after draw down of United Nations Mission in Liberia (UNMIL) peacekeeping forces, tackling rampant corruption, reducing the high level of unemployment, and continuing to reconstruct the country's infrastructure.

1.2 Health Situation

The long conflict had a devastating effect on the health system in Liberia. Health facilities were looted, destroyed, and abandoned across the country. Health workers fled and the schools for developing new health workers crumbled during the war, leaving only one functioning medical school which graduated just 13 doctors in 2007. Three quarters of Liberia's 380 functioning health facilities⁷² do so now only with the assistance of non-governmental (NGO) or faith based organizations (FBO).⁷³

The full human cost of the conflict as well as the persistent impact several years on is only now becoming clear. The 2007 National Demographic and Health Survey found that maternal mortality ratio has worsened from 578 to 994 deaths per 100,000 births since 1999, representing over one third of all deaths amongst women between ages 15-49 years.⁷⁴ Malnutrition in children remains a major

⁷⁰ A 2007 Gallup Poll (published in the New Democrat, 7 March 2008, Monrovia) reported 68% of Liberians said the 2005 elections were fair and 74% of Liberians have confidence in the Government, both figures significantly above the West African sub-regional average;

⁷¹ A national census will take place from March 2008, with final results expected by 2010;

⁷² It seems difficult to determine the health service delivery coverage in Liberia. Several presentations state it to be 40% but nowhere is clarified where this is based on. This appears low, given other findings.

⁷³ Ministry of Health & social Welfare's (MoHSW) Rapid Assessment of the Health Situation in Liberia, 2006;

⁷⁴ This rate reflects the maternal deaths during the 7-year period before the survey. However a 2007 reproductive health survey in Lofa county (see: UNFPA, USAID, JSI and CDC *et al*, "Women's reproductive health in Liberia- the Lofa County

problem with 7% moderate acute malnutrition, of which almost 3% severe.⁷⁵ A nutrition analysis in December 2007 found that nearly one in five deaths in children under five is attributable to malnutrition.⁷⁶ However, the infant mortality rate reduced from 117 to 72 per 1000 and the under 5 mortality from 194 to 111 over the same period, possibly linked to improved immunization coverage.⁷⁷

Despite these figures the Government of Liberia, through its Ministry of Health & Social Welfare (MoHSW), has made important progress towards improving the situation. A comprehensive National Health Policy and Strategic Plan were developed in 2007, which prioritize provision of a Basic Package of Health Services, rebuilding infrastructure and investing in human resources for health. The principle challenge in the health sector will be implementation of the Policy & Plan in a context where an overwhelming majority of services are dependant upon support from NGOs and FBO's.

1.3 Previous Research

The critical role of NGOs in Liberia was highlighted in a 2005 Liberia Interagency Health Report⁷⁸ in which a 'grim picture was painted of a population emerging from fourteen years of conflict in a situation which is not much better,' as humanitarian funding was uncertain and neither development funds nor partners were ready to participate in the transition from relief to development. Amongst others things, it strongly recommended improving coordination, strategic planning, and delivery of an essential package of basic services at the primary care level. Subsequent to that 2005 Interagency Report, a Rapid Assessment of the Health Situation in Liberia was carried out in 2006 by the Ministry of Health and Social Welfare exploring management and level of resources available at health facilities, which lead to the development of the strategic health plan.⁷⁹ A follow-up Interagency Health and Nutrition mission was carried out in December 2006. That report recognized the progress made in policy and planning but that also highlighted a pending transitional funding gap for health service provision and the need for donors to make increased and better coordinated commitments to funding health.⁸⁰ This report sheds light on what has happened since with respect to the health sector in the transition of relief to development funding.

2. Trends in Funding Support to the Health Sector

2.1 The transitional funding gap has been avoided

To determine the status of health sector funding in the transition from relief to development, semi-structured interviews were held with a wide range of key stakeholders involved in the health. The aim of the interviews was to learn whether

Reproductive Health Survey January–February 2007") concluded that of the recent deliveries almost 50% took place at home without a skilled medical person attending. Furthermore, over 75% of the women reported complications during recent pregnancies, whereby 20% of them did not seek medical help, highlighting again the potential scope of the problem.

⁷⁵ LISGIS, MoHSW, NACP, MEASURE DHS, "Liberia demographic and health survey 2007- Preliminary report", 2007

⁷⁶ MoHSW/AED/World Food Programme, Nutrition Policy Analysis using PROFILES: Investing in Nutrition to Reduce Poverty.

⁷⁷ In 2005 WHO immunization monitoring had reported improvements with DPT-3 at 87% and measles at 94% as reported in the 2007 MoHSW National Health Policy on p.9-10

⁷⁸ Msuya and Sondorp, "Interagency Health Evaluation Liberia, September 2005, final report", 2005

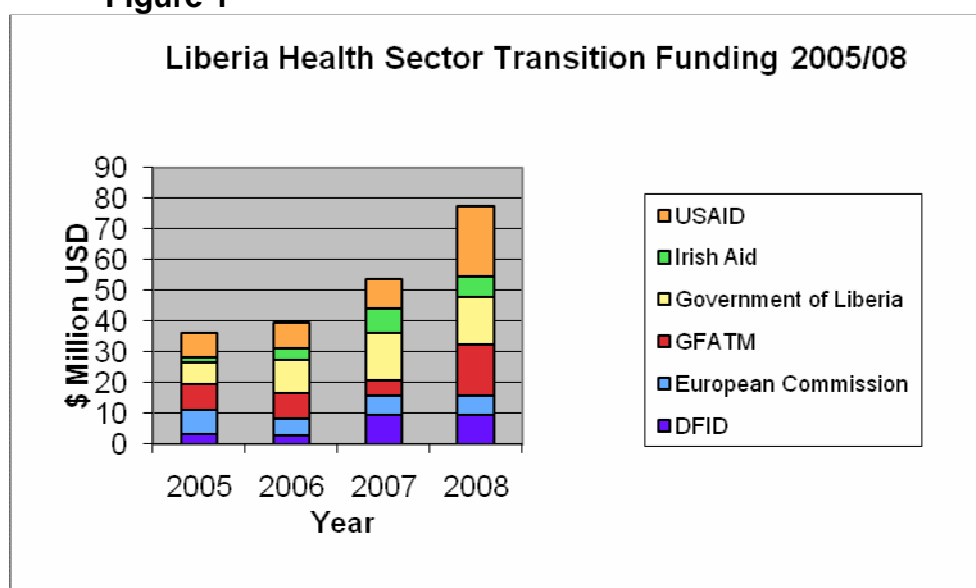
⁷⁹ Republic of Liberia Ministry of Health and Social Welfare, "Rapid Assessment of the Health Situation in Liberia", June 2006

⁸⁰ Sondorp and Bornemisza, "Inter-agency Health and Nutrition Evaluation Initiative- Follow-up Mission to Liberia, December 2006", 2007

the funding gap for health service provision that was anticipated in 2006 actually occurred, thereby indicating the level of aid effectiveness experienced in Liberia during the transition. Major donor contributions to the health sector between 2005 and 2009 were also investigated to corroborate the findings of stakeholder interviews.

Figure 1 presents the funding levels to the health sector between 2005 and 2009. In purely monetary terms, it is clear that health funding has not decreased during the transition from relief to development.

Figure 1⁸¹



The stakeholder interviews confirmed that there has not been a reduction in health funding and revealed the importance of the Washington Partnership Forum held in early 2007. At a side-bar meeting to the Forum, the Minister of Health and Social Welfare, Dr. Walter T. Gwenigale, presented a compelling picture of what would happen if NGOs and faith-based organisations (FBOs), supporting 77% of the service delivery in Liberia, were to scale down due to reductions in donor funding. The Minister explained that the Government of Liberia was not yet in a position to assume full stewardship of service provision in Liberia. This resulted in the extension of ECHO funding to its existing partners and increased contributions by Irish Aid and DFID to the health sector, as indicated in Table 1.

The advocacy undertaken by NGOs and the support provided by donors to assist the MoHSW to raise the alarm during the Forum are thought to have played an important role in avoiding the health funding gap, as was the decision by the Minister to request NGOs and donors to continue their support for at least another two years. The importance the international community assigns to Liberia, as

⁸¹ The table above does not include all sources of funding. For purposes of presenting the health system funding over time, only major donor contributions and Liberian government funding is included. Known 2007/08 health funding includes at least \$83 million USD from major and minor donors, international agencies, philanthropic organizations and NGO private funds, in addition to the estimated \$20 million USD derived from individual health expenditure (MoHSW 2008 & WHO 2006). The 2006 USAID Health Funding level is estimated.

evidenced by the commitments made at the Partners Forum, was highlighted by one donor interviewed:

“...internationally the government is well regarded with good reformist credentials. Important, not only to Liberia but to the wider post-conflict scene in Africa, that they should succeed rather than revert back to conflict. This would have repercussions on wider Africa but also on the region as it was seen that e.g. there could also not be peace in Sierra Leone without peace in Liberia, as well as other neighbouring countries.”

With the continuation of funding, health service delivery has continued in largely the same manner as during 2005 and 2006; health facilities provided services with external support from FBO and NGOs. There were, however, interruptions to the grant agreements between some NGOs and their donors. One NGO mentioned a three-month delay in receiving funding during the period directly prior to the Washington meeting, when presumably donors were taking a ‘wait and see’ approach, after which funding came through relatively quickly. Several other NGOs mentioned experiencing substantial delays in receiving funding during previous years; funding USAID, Global Fund and CERF was mentioned as having been slow to materialize. However, no delays affected the actual delivery of health services, while activities such as training were sometimes temporarily suspended.

The fact that Liberia was not successful for round 6 of malaria and TB proposals under GFATM did result in programmes coming to a halt. While the malaria program bridged activities with support from the President’s Malaria Initiative as well as other discrete funding arrangements, the TB program experienced major problems and had to scramble to find TB drugs for those already undergoing treatment. Fortunately a small German foundation was willing to support provision of drugs, but the TB program was quite affected by the funding gap and continues to have inadequate resources.

The withdrawal of MSF Holland and France from Liberia in the beginning of 2007 resulted in the handover of primary health care clinics they were supporting to other NGOs. Most NGOs said this handover had been discussed months in advance. For some organizations it was no problem to assume support for these additional clinics, while another organization mentioned that this was just before the Washington Partners meeting when they were faced with insecurity on the continuation of funding for their own program. The subsequent funding provided by ECHO, DFID and Irish Aid, following the Washington meeting ensured the continued support to the clinics.

However, MSF’s withdrawal from several secondary health care facilities in 2005-2006 has been highlighted as causing gaps in referral service delivery. Two important hospitals providing referral services in Monrovia were handed over to the MoHSW. Redemption hospital was handed over to the MoHSW for ongoing management, while Mamba point hospital (an interim, 100-bed hospital established by MSF during the conflict) was incorporated into the existing national tertiary hospital, the John F. Kennedy Hospital (JFK). When interviewed, the MoHSW expressed that at that time they were unable to provide the required level of funding and drugs to ensure the service delivery would not be affected. It was

reported by both the Ministry and NGO representatives that the situation has improved at Redemption hospital since MSF withdrew.

2.2 Has the transition been delayed?

It is plausible that the extension of support to the humanitarian agencies for a further two years has potentially just delayed the transition from relief to development. But discussions with the main donors revealed a general commitment to ensure no health service funding gap will occur:

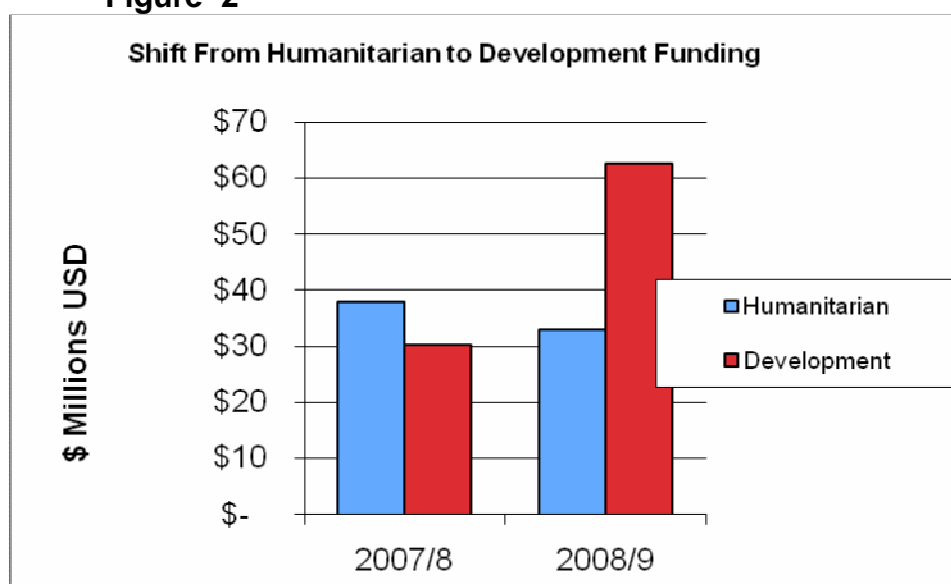
- As it is essential under the European Development Fund (EDF) to have a reliable counterpart willing to participate in the oversight of the fund, the 9th round of the EDF did not provide funding to the Liberian health sector (the transitional government was not willing to discuss long-term health plans). In light of this and the persistent humanitarian need in many areas, the European Commission has extended its humanitarian funding in Liberia, at the same level and through ECHO until June 2009. The importance of ensuring a gap will not materialize as a result of the shift from ECHO to EDF funding was made clear during the interviews. Both the EC and the ECHO in-country representatives expressed the strong desire to ensure overlap between ECHO funded projects and the 10th EDF, which is intended to come on stream in 2009 (potentially through pool fund, see section 3.2).
- DFID and Irish Aid have both continued and increased their funding to the NGOs supporting the health sector since 2005, but are planning a gradual shift from direct project aid to a more developmental approach. Both expressed intent to fund health through the pooled fund in order to increase MoHSW stewardship. DFID funding to NGOs is currently following an 18-month cycle that finishes at the end of 2008 and they are discussing new arrangements to provide long-term assurances of support. DFID said it is intending to change its approach from bi-lateral to tri-lateral with future agreements being made between MoHSW, and the NGOs. Irish Aid will follow DFID's approach.
- USAID also expressed its commitment to ensuring continuity between OFDA and USAID supported health services. In the second quarter of 2008, USAID will launch a Request for Applications (RFA) for continued support to at least the 71 clinics previously supported by OFDA, as well as to strengthening professional training for health workers.
- With support mainly from the USBPRM, UNHCR has been providing funding to three local NGOs to support about 60 clinics. UNHCR is winding up their activities at the end of 2008 and is unsure who will assume responsibility for the clinics they support. UNHCR felt that MoHSW does not have the current capacity to take on this responsibility, based on pilots of handovers done in Nimba last year, when medical staff was not put on government payroll and essential drugs and medical supplies were lacking several months after the handover.⁸² However, those BPRM/UNHCR facilities within counties where USAID will be supporting will be included in the upcoming RFA. In addition, funds are also being solicited through the current Critical Humanitarian Gaps Appeal, launched by the UN in March 2008, to continue supporting the remaining BPRM supported facilities that are not in counties where USAID will be supporting.

⁸² UNHCR, "Global analysis of health situation in Nimba County, February 29, 2008", 2008

- GFATM continued support since 2005 and has increased its contributions for 2008, significant funds have also been allocated for 2009 and beyond. The primary recipient and grant funds manager is UNDP but this responsibility will begin transferring over to the MoHSW in June 2009.

Figure 2 further demonstrates that a further shift from relief to development funding is anticipated during 2008/2009. It also reveals that overall increases in health sector funding show in Table 1 can be attributed to increases in development funding.

Figure 2⁸³



It is important to note that from the 07/08 to 08/09 Government of Liberia fiscal years the amount of resources available for health service provision will not decrease, provided pool funds are used for health service provision. Contracting out to NGOs will be piloted in the coming months and may, if successful, be a means of continued provision of health services with NGO support, through the pooled fund. However, the Health Minister noted that this might only be a short-term solution while the question remains on the long-term sustainability of services when the future of funds is unpredictable and likely to be lower.

Many of the NGOs highlighted that at this stage it is unclear to them how exactly the transition from relief to development funding will affect them. Some NGOs mentioned that donors have requested them to provide an exit strategy in the upcoming year, whereas others noted that the MoHSW had expressed not being able to take on the support role provided by NGOs for another five years. What is lacking is a disseminated, operational plan on how support to the health services, including secondary health services, will be sustained so as to ensure appropriate levels of care in the long-term.

The handover of the responsibility for supporting clinics (e.g. paying staff, supervision, supplying medicines) from NGO to MoHSW responsibility can

⁸³ Table 2 does include all known sources of health financing in Liberia, except estimated out of pocket payments.

consider a phased approach, e.g. handover of several clinics in each county or a subsequent handover of the different counties to the MoHSW. This needs to be based on a sound health facility coverage strategy.⁸⁴ The necessity for the latter, so as to ensure an equitable health service delivery, is also highlighted in the 2007 Basic Package of Health and Social Welfare Services plan⁸⁵ and is recommended to be developed as soon as possible. It should be supported by focused capacity building and institutional strengthening over the coming years. The contracting approach, if deemed successful, can support this process. Such a strategy will provide clarity to the role of all actors involved in the service delivery as well as those (intending to) providing technical assistance and capacity building. Moreover, it will allow the MoHSW to guide this handover process rather than depend on the withdrawal or transition from relief to development funding of individual donors.

The support of donors and NGOs to the development of such an overall handover strategy is vital. Special consideration should also be given to the role local NGOs and FBOs are to play in service delivery, especially as many of them will be active in Liberia long after international agencies have departed.

The withdrawal of actors contributing to secondary health services also needs to be taken into consideration. MSF delivers hospital services in Monrovia and Nimba and the different sections intend to depart during 2008-2009.⁸⁶ In addition, the impact of the scaling down of UNMIL needs to be factored. While they are not a traditional health service provider, UNMIL has been providing some health services as well as logistic support (roads and infrastructure are still a problematic in many areas). A County Health Officer interviewed, described how the Pakistani medical contingent assists in the hospital, providing services such as dental care and X-rays as well as electricity 24 hours a day.

2.3 Resource allocation of health funding and *per capita* spending

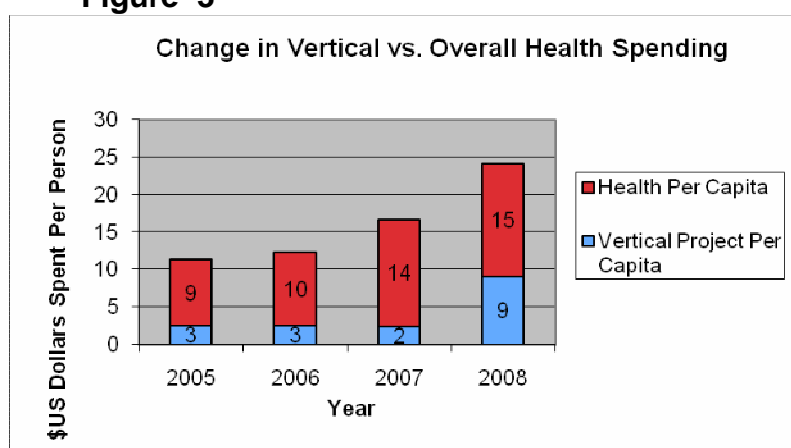
While there has been a quadrupling of funding for vertical projects in Liberia, Figure 3 below further demonstrates that the *per capita* spending on health services has not decreased during the transition.

⁸⁴ It is difficult to determine current health service delivery coverage from a population perspective. MOH presentations state it to be 40% based on internal MOH staff assessments. The recent United Nations "Critical Humanitarian Gaps in Liberia: 2008" names 41% and refers to the 2007 LDHS, but the LDHS preliminary report does not seem to contain information on health service delivery coverage. This same report finds the Antenatal Care coverage to be 79%, which gives the impression that 41% health service delivery coverage is rather low. Especially, given that 30% of the population is living in Monrovia whereas NGOs are supporting health services in each county.

⁸⁵ Republic of Liberia, Ministry of Health and Social Welfare, "A Basic Package of Health and Social Welfare Services For Liberia", Draft 10/13/2007

⁸⁶ MSFB is committed to continue support to Island hospital (with 77% of the paediatric beds) in Monrovia until 2009. MSF Swiss intends to handover to the MoHSW a comprehensive health facility with 34 beds in Nimba in July 2008; while there are NGOs interested to provide additional support, funding has not yet been secured. MSF Spain provides MCH services from a (private) hospital in Monrovia where and may withdraw its support at the end of 2008.

Figure 3



Major sources of health funding only, including GoL but excluding out of pocket payments;

With 65% of vertical project funding directed in 2008 at malaria control, it can be argued that additional health resources are being targeted at traditionally leading causes of morbidity and mortality in sub-Saharan Africa.⁸⁷ During interviews, some stakeholders raised concern about 23% of vertical funding being allocated to HIV whilst prevalence is generally low, according to the 2007 DHS, as well as with funds being spent more on treatment than prevention.

A critical factor to bear in mind when analyzing the *per capita* spending in Liberia is that, whilst it surpasses other West African countries, it does not include the full cost of reconstructing the health system; comparatively little of the overall health spending is on reconstruction of vital health infrastructure or on long-term human resources development.⁸⁸ High reconstruction costs were conservatively estimated in the costing of the National Health Plan, leading to inconsistencies between estimated implementation costs and actual health spending. In Table 1 we see that the estimated total 2007/8 health expenditure in Liberia is twice what was projected.

Table 1

Total Estimated 2007/8 Health Expenditure in Liberia				
Source of Funding	National Health Plan Estimate (US\$ million)	Actual (US\$ million)	Actual US\$ <i>per capita</i>	% of total expenditure
Government	10	15	5	14%
Out of Pocket ⁸⁹	4	20	6	18%
All Donors & Foundations	40	76	24	68%
Total	54	111	35	100%

⁸⁷ The vertical project funding included is GFATM & PMI. Clearly delineated health system strengthening (HSS) makes up less than 10% of the vertical funding indicated; however, Liberia will submit for HSS under GFATM Round 8 for HIV.

⁸⁸ HLSP, Pearson, "Funding flows for health: what the future might hold," 2007.

⁸⁹ Although user fees are officially suspended, informal payments are widely charged. A WHO report, "Review of Health Financing Situation in Liberia," 2006 estimates out of pocket and private sector annual health spending at close to \$20 million USD.

However, the preliminary findings of the recent DHS⁹⁰ reveal the health needs are still high. The fact that this cannot be reliably substantiated by other comprehensive mechanisms for monitoring health statistics highlights the importance of the developing a Health Information Management System, allowing evidence based planning and management of the health system. Even the implementation of the Basic Package of Services will not address all health needs as it prioritizes activities based on criteria such as the impact on morbidity and mortality as well as the likelihood of carrying out the services in light of available resources. As a consequence, the focus is mostly on primary health care and important (post-conflict) health activities, like mental health, have been made less of a priority for the time being.⁹¹

As mentioned, merely focusing on the gap in the service delivery (post-conflict) may not be reflective of the needs in a post-conflict country. Many of the health facilities and support services are below standard or non-operational. The Health Minister highlighted the need for staff with management experience and donor fund management experience. The demand for such capacity and the strengthening of institutions is likely to be even larger due to the policy to decentralize responsibilities to the counties in Liberia. A County Health Officer described the positive developments since the current government is in office, such as funds coming available and regular supplies of items like fuel and staff incentives. The need for further improvements was made as requests for funds to pay for other services such as vehicle maintenance have been experiencing significant delays at central level, consequently hampering referral and supervision activities and continuing the reliance on international NGO support.

3. Aid Effectiveness in the Health Sector

3.1 Alignment and changing approaches to health funding

Several of the donors and UN agencies expressed that, while recognizing that emergencies occur in Liberia, it is right to talk about a transition from relief to development, as the balance of attention has to shift away from emergencies to development objectives. The transition is not working perfectly as the government has such huge capacity challenges and institutions are not necessarily in place; however, the approach has changed to more engagement with government. The Liberia Reconstruction and Development Committee (LRDC) highlighted though that:

“Aid effectiveness is still a challenge as the international community has run Liberia as a government for so long, it is hard to take it back. There needs to be recognition that government provides leadership. The issue of capacity challenges is often mentioned but it is not always clear how this is built by the actors involved.”

⁹⁰ LISGIS, MoHSW, NACP, MEASURE DHS, “Liberia demographic and health survey 2007- Preliminary report”, 2007

⁹¹ Republic of Liberia, Ministry of Health and Social Welfare, “A Basic Package of Health and Social Welfare Services For Liberia”, Draft 10/13/2007, p.3-4

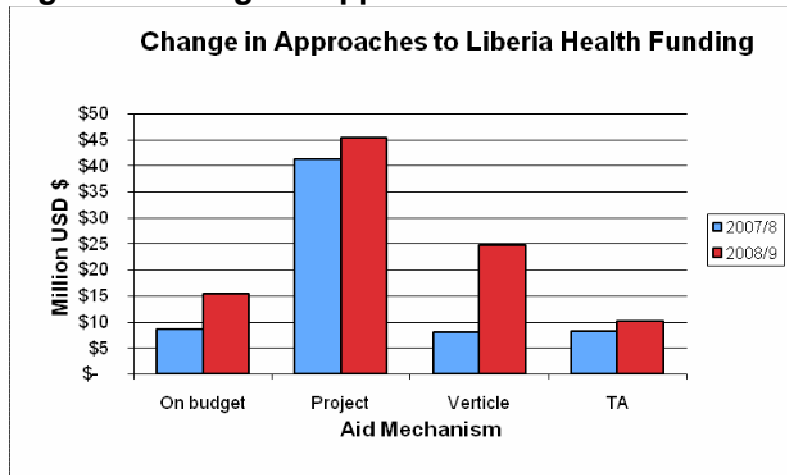
Progress is being made, as an overall poverty reduction strategy will be implemented for Liberia from mid-2008, donors do support the national health plan, and NGOs write proposals based on the objectives of the plan and how they can contribute. Policies developed by the Ministry are increasingly guiding the decision making process. One example being the Basic Package of Service, which has led to a more integrated approach to health services, countering the increase in disease focussed funding. Some resource tensions exist though, as all humanitarian service provision funding continues to be channelled to NGOs and the current focus is still largely on service delivery, whereas the MoHSW feels there is a need to also ensure that infrastructure development, systems and capacity building are prioritized as well.

The national health plan reflects these needs by focusing on human resource development, infrastructure destruction and strengthening of support systems. It was highlighted by donors, however, that the National Health Plan has areas that require further work with respect to realistic costing and realistic timeframes. This strengthening is seen as a precondition by most of the development donors, such as EC and DFID, before a sector-wide approach could be initiated. It also requires discussions and a review of the relationship between the MOH and partners (incl. NGOs, private sector and FBOs) to ensure a coherent and coordinated implementation. Coordinated implementation is a challenge that requires a certain ability of the MoHSW to lead, an issue of debate amongst stakeholders. Several of those interviewed stated that while there is significant information sharing with the Ministry, real coordination is still lacking; conversely, INGOs continue to use parallel coordination mechanisms.

Continuous Technical Assistance to the MoHSW on health issues has been provided mainly by the Clinton Foundation. While specifically focusing on HIV, they have provided significant support to the MoHSW in other areas by filling gaps in capacity building identified by the Ministry, sometimes as a result of delays in assistance planned to be provided through other projects. This underscores the importance of experienced institutional strengthening advisers being mobilized to provide timely support to a post-conflict country, and not only at central level, but also at county level given the intended decentralization.

The Government of Liberia and the MoHSW are in favor of budget support but realize that most of the donor partners are waiting until fiduciary concerns have been mitigated. The UN explained it had offered to establish a MDTF for social services, but the GoL declined, expecting that it would be too slow. Nevertheless, main development donors are interested to move away from a project approach with high transaction costs, and this has led to the development of a pool fund for the health sector. Most interested donors will initially have a two-track approach with continued direct funding to NGOs while making contributions to the pool fund. USAID is not in a position to take part in the pooled fund due to restrictions on co-mingling of US Government funds; it will instead contract to NGOs and external companies through competitive bidding processes. Both the EC & World Bank have indicated that future health funding will be channelled through the pool fund, explaining why in Figure 4 there is an increased amount of funding 'on budget' as well as an increase in funding to 'projects'.

Figure 4: Change in Approaches to Liberia Health Funding



All sources of health funding, including GoL but excluding out of pocket payments;

3.2 The health sector pool fund in Liberia

As Table 2 indicates, Section 2, over \$100 million USD is projected be spent on health in 2007/8 from over twenty different sources. Such a large number of health financing actors presents an enormous coordination challenge for the MoHSW and risks high inefficiency. After engaging in a participatory exploration of potential aid mechanisms, the Government of Liberia decided to support the establishment a supervised basket or 'pool fund' in the health sector. A supervised pool fund has two principle purposes in the current context: 1.) to increase alignment with government policy and plans, reinforcing the stewardship role of the MoHSW; 2.) to reduce the time and effort the Liberian government must spend managing multiple streams of support, reducing transaction costs and improving efficiency. Pool fund 'oversight' addresses concerns about premature provision of general budgetary support and provide satisfactory fiduciary risk assurances to potential contributing donors.

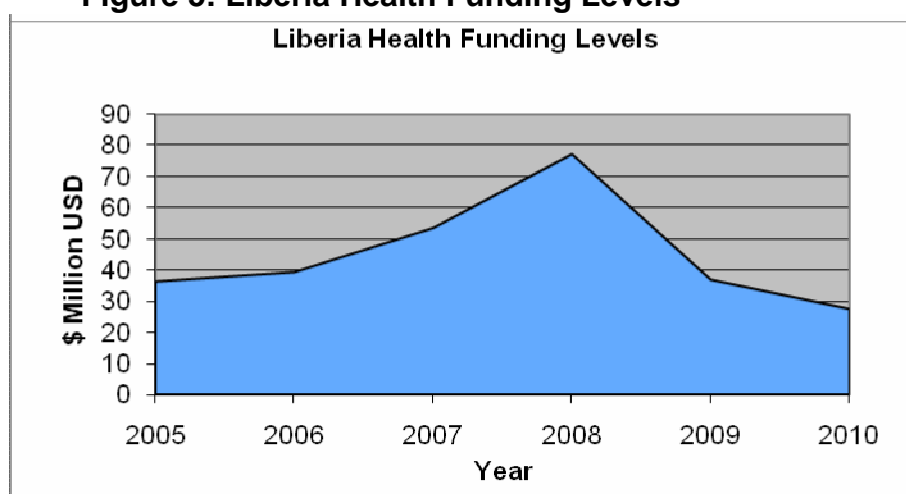
The pool fund was established in March 2008, with the United Kingdom's DFID role of 'lead donor' for the pool fund and an initial contribution of \$8 million USD. Other donors that have expressed interest in using the mechanism, provided it functions well, include Irish Aid, GAVI and the European Commission. In its capacity building role within the Ministry of Health's Office of Financial Management (OFM) and through its existing contract with DFID, PricewaterhouseCoopers has been engaged to receive funds into a co-signatory account separate from the GoL funds and oversee their disbursement. The pool fund mechanism functions with a lead donor, contributing donors and a fund management function in the OFM, with the MoHSW proposing allocation priorities consistent with the National Health Plan for endorsement by a Pool Fund Steering Committee (a joint donor, MoHSW committee). This allows for a flexible use of the funds, based on information about needs as it becomes available, especially important during this time of transition and reiterated by many stakeholders. The OFM disburses funds and reports on their use.

This pool funding is a possible interim step on the path to budget support. The lifespan of the pool fund will therefore be influenced by progress made towards financial transparency and governmental accountability. GoL hope they will have made sufficient progress in strengthening their public financial management systems to qualify for direct budget support over the next two to three years. Failing this, it is possible that the MoHSW will have made sufficient progress in financial management strengthening to be a candidate for direct sectoral budget support by the end of the OFM project (mid 2009). Therefore the initial lifespan of this pool fund will be around three years.

3.3 Aid predictability

Figure 5 highlights that there is little long term insight into donor pledges. Of the major sources of health funding, currently only Global Fund and USAID funding levels are known beyond 2009. This results in challenges for longer term planning for the health sector. The Minister stresses the importance of this predictability as: “an investment of \$34pp would require about \$118M a year, which constitutes 50% of the total government budget. Hence, outside help is needed for a long time to come.”

Figure 5: Liberia Health Funding Levels



Major sources of health funding only, including GoL but excluding out of pocket payments;

It is important to note though that donor pledges do not necessarily provide predictability as, according to the LRDC, a UNDP study carried out in Liberia in 2006 showed that only 40% of what was pledged in 2004 was actually disbursed and spent. The LRDC is currently trying to gain insight into donors commitments over the coming three years and, while it has been difficult to get data, they would rate the cooperation of donors at 3 on a scale from 1 to 5. In preparation for the Accra High-Level Forum meeting, the LRDC is also involved in compiling the results of the Paris Declaration surveys to assess progress and identify obstacles and opportunities to improve aid effectiveness in the country.⁹² Through a formula based on economic recovery indicators and based on a theory that States require

⁹² OECD DAC, “2008 Survey on Monitoring the Paris Declaration, Accra High-Level Forum on Aid Effectiveness”, on <http://www.emansion.gov.lr/lrdcpublishers/aiddocs/ExplanatoryNote.doc>, 2008

external assistance until they can independently finance the basic service entitlements of its citizens, the Centre for Global Development have recently estimated that donors should not expect to disengage from Liberia until 2018.⁹³

The United Nations is in the process of launching a Critical Humanitarian Gaps Appeal requesting \$28M for Liberia. Rational for the report includes:

“...as is often the case in transitional situations, resource mobilisation for development is subject to delay, and adequate funding for the PRS and UNDAF will take time to come on line. In the meantime, resources are needed to ensure that the critical humanitarian gaps and needs of highly vulnerable communities during this important transitional period are addressed...Liberia has relied mainly on the support of international humanitarian organisations to provide basic social services, many of which have closed operations or are scaling back in light of reduced funding. The situation in Liberia is a reminder that the international community has yet to come to grips with the humanitarian-to-development gap.”⁹⁴

This contrasts with Tables 1 & 2, Section 1, with respect to funding flows for health to Liberia and interviews conducted with stakeholders that largely indicate basic service provision continuity and that little or no health services interruptions as a result of funding. However, NGOs supported through the UN with funding from CERF and USBPRM are potentially at risk, if pool funding is not be allocated to ensure clinics they support remain open. The appeal indeed asks for \$1.5M to maintain this support.

Approximately \$4M of the appeals \$7M requested for health are for the UN to implement activities such as emergency response to epidemical diseases, immunization campaigns, and distribution of reproductive health kits. These are important activities, but the importance of health system strengthening to ensure their sustainability has been highlighted during interviews. Less than \$1.5 M is allocated to extend the health service delivery coverage, through the support of an additional 6 clinics in Rivercess County, the reopening of a health centre in rural Montserrado County, as well as addressing maternal health needs by increasing emergency obstetric care in three counties. Sustainability of all these activities still needs to be considered as any funding from the appeal will be for maximum 1 year. UN appeals for Liberia in 2007 were funded to only 62% and health received only 29% of what was requested in 2007 and only 13% in 2006.⁹⁵ Several stakeholders expressed the risk of duplication due to the unpredictability of such funds, begging the question if this is the most reliable funding mechanism to be used for the health sector in a transition period.

3.4 Harmonization of aid

Speaking to stakeholders, it became evident that many times before people have come to visit asking questions; most of the time to do assessments, sometimes to

⁹³ The Centre for Global Development; “Working Paper Number 141: How Soon Can Donors Exit From Post-Conflict States?” Chand & Coffman; February 2008.

⁹⁴ United Nations, “Critical Humanitarian Gaps in Liberia: 2008” on [http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/2008_Liberia_CHG/\\$FILE/2008_Liberia_CHG_SCREEN.pdf?OpenElement](http://ochadms.unog.ch/quickplace/cap/main.nsf/h_Index/2008_Liberia_CHG/$FILE/2008_Liberia_CHG_SCREEN.pdf?OpenElement), 2008, p.1

⁹⁵ United Nations, “Critical Humanitarian Gaps in Liberia: 2008”, Op. Cit., p.2-3

carry out studies. The impact on the Ministry, with rather limited capacity, will also be significant. One person said:

“There are 1000 duplicating assessments, including yourself, e.g. EC capacity assessment, health assessment, USAID assessment of training institutions, someone who looked at what capacity was needed in clinics, a Harvard medical team looking at capacity. There is no info sharing going on, all ask the same questions.”

Donors did seem to recognize this. The effect of USAID’s competitive approach with an upcoming RFA has also led many, especially USAID funded organizations to come and in anticipation of funding that will become available.

While there may be duplicating assessments, donors have been able to coordinate to prevent duplication in implementation, examples include: the MoHSW financial management system strengthening which was initially intended to be done by USAID but taken on by DFID; or the importance that the EC attributed to developing a health information management system as soon as possible, but at the same time recognizing that this was something USAID was intending to carry out. However, the lengthy approval processes of donors can sometimes cause delays. USAID explained, for example, that it can take 1 year for plans to materialize due to lengthy approval mechanisms. There may be scope for discussion amongst donors to not only ensure duplication is prevented but also to coordinate which donor is best positioned to provide certain services in the shortest timeframe possible, so as to allow the starting of essential activities such as capacity building or urgently needed system strengthening as soon as possible. The provision of a Technical Adviser to the Planning, Research & Development Department of the MoHSW, in support of international aid coordination and resource mobilization, was highlighted by several donors as having been very beneficial in providing insight into resources.

3.5 The effectiveness of aid

None of the stakeholders interviewed was aware of any evaluation undertaken of the effectiveness of aid in Liberia. LRDC has some intention to do this some time in the future, once donor tracking is further established. Most implementing agencies carry out project evaluations, often depending on donor requirements. Some donors expressed an interest in joint evaluations in the future.

3.6 Recommendations for Liberia

- An operational plan, based on sound health facility coverage strategy, should be developed to accompany the National Health Plan in order to ensure continuity of health services, including secondary health services, during the transition. Consideration should be given to the role (local) NGOs and FBO’s will play in the overall service delivery. The transition of responsibility for supporting clinics (e.g. paying staff, supervision, supplying medicines) from NGO to MoHSW should be included. A phased approach could be followed which would allow focused capacity building and institutional strengthening. The contracting approach, if deemed successful, could support this process. Such a

plan will provide directional clarity to all actors involved in service delivery and allow the MoHSW to guide this transition process, rather than depend on funding flows and decisions from individual donors. The support and participation of donors and NGOs to the development of such an overall handover strategy is vital.

- A follow up to this study recommended to be carried out in 2009 to evaluate whether the transitional funding gap has been merely delayed or completely avoided. This will further allow the development of an evidence base on transitional issues.

3.7 Overall lessons learnt, based on Liberia case study

- Consideration needs to be given whether it is beneficial to carry out appeals during times of transition from relief to development funding, given they are demanding to prepare but have a limited return and as such do not seem a reliable funding mechanism to be used for the health sector in a transition period.
- Enhanced coordination is recommended amongst donors to not only ensure gaps and duplication are prevented, but also to coordinate which donor is best positioned to provide certain support in the shortest timeframe possible, so as to allow the starting of essential activities such as capacity building or urgently needed system strengthening as soon as possible.
- The provision of a Technical Adviser in support of international aid coordination and resource mobilization was highlighted by several donors and the MoHSW as having been very beneficial.

4. Bibliography

Chand & Coffman. 2008. *How Soon Can Donors Exit From Post-Conflict States?* Working Paper Number 141. The Centre for Global Development

LISGIS, MoHSW, NACP, MEASURE DHS. 2007. *Liberia demographic and health survey 2007- Preliminary report*

MoHSW/AED/World Food Programme, *Nutrition Policy Analysis using PROFILES: Investing in Nutrition to Reduce Poverty*

Msuya, C. Sondorp, E. 2005. *Interagency Health Evaluation Liberia, September 2005, final report*

OECD DAC. 2008. 2008 Survey on Monitoring the Paris Declaration, Accra High-Level Forum on Aid Effectiveness.

Pearson. 2007. *Funding flows for health: what the future might hold.* HLSP

Republic of Liberia, Ministry of Health and Social Welfare. 2007. *A Basic Package of Health and Social Welfare Services For Liberia, Draft 10/13/2007*

Republic of Liberia, Ministry of Health & Social Welfare. 2006. *Rapid Assessment of the Health Situation in Liberia*

Republic of Liberia, Ministry of Health and Social Welfare. 2007. *National Health Policy*

Sondorp, E. Bornemisza, O. 2007. *Inter-agency Health and Nutrition Evaluation Initiative- Follow-up Mission to Liberia, December 2006*

UNFPA, USAID, JSI and CDC et al. 2007. *Women's reproductive health in Liberia- The Lofa County Reproductive Health Survey*

UNHCR. 2008. *Global analysis of health situation in Nimba County, February 29, 2008*

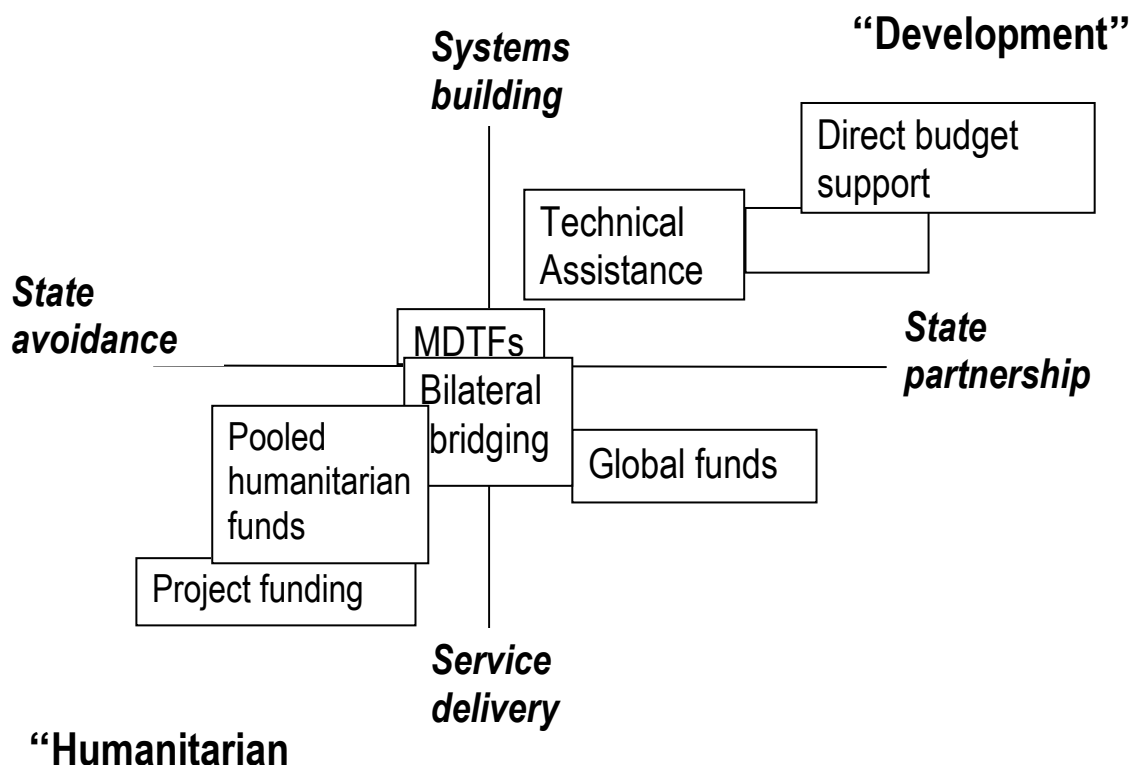
United Nations. 2008. *Critical Humanitarian Gaps in Liberia: 2008*

Liberia Key Informants	
Claudette Bailey	Africare
Ellen B. George William	Christian Health Alliance of Liberia
Peter Ehrenkranz	Clinton Foundation
Desmond Curran	DFID
Fimia Ocampo	ECHO
Jean-Louis Alexandre	EC
David Waines	Equip
David Logan	GFATM / LCM
Grainne ONeill	Irish Aid
Sylvie Loucher	IRC
Elizabeth Williams	JSI / BASICsx
Gama Roberts	LRDC
Natty B. Davis, II	LRDC
Estelle Dogbe	MSF B
Mariano	MSF Spain & Swiss
Kristin Banek	Mentor
Sonja van Osh	Merlin
Jacob Hughes	Aid Coordination Adviser MoHSW
Dr. Gwenigale	Minister of Health and Social Welfare
Dr. Bernice Dahn	MoH&SW
Bill Martin	Senior Adviser MoH&SW
Dr. Lynd Bearch	MoH&SW
Sr. Barbara Brilliant	Mother Patern
Susan Grant	Save the Children UK
Dr. Hari Banskota	Save the Children UK
Maura Lynch	UNMIL
Renata Dubini	UNHCR
Dr John Agbor	Unicef
Dr. James Dworko	USAID
Dr. Eugene Nyarko	WHO

ANNEX 6 - COMMON AID INSTRUMENTS IN TRANSITIONS

Aid to the health sector in settings that are recovering from conflict is often typified as addressing the tension between the (often conflicting) aims of immediate life saving and systems building. This can imply adoption of a state avoiding or state supporting approach. A traditionally “humanitarian” approach would be extremely state avoiding and service delivery focussed, whereas a traditional “development approach” would see the state as a partner with the primary aim of systems building. Figure 1 illustrates the chronology of aid instruments in line with efforts to move towards aligning with national policies and building local capacities. Therefore the dichotomies are not discrete as humanitarian funds can address elements of district level capacity building for health workers thus engaging in state partnership at the decentralized level of the state. Thus, humanitarian agencies are positioned to foster engagement with the government at the early recovery phase and are often the only agencies on the ground to do so. Development agencies assume the responsibility for long term resource mobilization and are expected to engender more integrated and sustainable approaches with government and civil society partners. Such efforts will foster ownership and promote a systems building approach in partnership with the national stakeholders.

Figure 1: Aid instruments



The following aid instruments are used in transitions where an aid instrument mix is commonly found to exist. They are explored here:

- i. Humanitarian pooled funding
- ii. MDTF's and other pooled funding mechanisms.
- iii. Direct Budget Support (DBS)
- iv. Global health initiatives
- v. Technical Assistance

i. Humanitarian Pooled funding

Pooled funding mechanisms (which include both common humanitarian funds and development variants) are best described where contributing donors agree to pool resources under a common management framework and where a steering group including national authorities, donors and multilateral institutions make decisions on allocations to sectors and projects.

The UN humanitarian reform initiatives coupled with the Good Humanitarian Donorship principles call for improved coordination in delivery of humanitarian aid. The humanitarian Consolidated Appeals Process (CAP) and Emergency Response Funds (ERF's) are UN led mechanisms to mobilize relief funds but are not viewed as useful mechanisms for recovery due to their project orientation and short term contribution⁹⁶. They have been augmented with the development of the Common Humanitarian Action Plan (CHAP) and associated Common Humanitarian Fund (CHF) which have been piloted in Sudan & DRC since 2006. The CHF was designed to increase the flexibility, timeliness and coordination of humanitarian funding by giving the UN Humanitarian Coordinator sufficient authority and resources to fulfil the priorities outlined in the UN Annual Work Plan.

A recent evaluation of the common funds for humanitarian action in Sudan and DRC⁹⁷ outlined a number of strengths and weakness of the CHF mechanism. Common or pooled funds have been credited with *improving coordination; prioritization and planning of interventions thus strengthening alignment with nationally agreed priorities in both pilot countries*. Findings suggest strong support for the ethos and principles of the CHF. But results also highlight that the aid mechanics need to be further improved, such as *a more efficient administration of the fund, balance of power between UN & INGOs, high transaction costs by UNDP for coordination of the mechanism, shift of burden from donors to field actors*. This was further amplified by NGO representatives:

“During relief phase there are multiple mechanisms, (CERF, CAP, CHF) available but they become inaccessible in transitions from relief to development; as an NGO we received feedback on the proposal that our approach was too developmental.”
(NGO spokesperson)

⁹⁶ Mowjee, T. (2006). *Review of OCHA Emergency Response Funds*.

⁹⁷ Stoddard *et al* (2007) *ibid*.

“Our experience of CAP's and CHF, it's almost impossible to access funding; they require a lot of energy to prepare and we get very little funds out of it so we rely largely on bilateral aid to support our projects.”
(NGO spokesperson)

Stoddard *et al* highlight the merits of the CHF and its potential as a precursor to more rigorous aid alignment beyond the early transition period.⁹⁸ This may provide a bridge given the traditional split between humanitarian and development funding which can affect the continuation of health service delivery. However, further attention is required to the need to refine the processes and implementation of the mechanism to ensure predictability, accessibility and availability of funds as well as a shifting the balance of power to an emerging government.

ii. MDTF and sector pooled funding mechanisms

While there are variants on pooled funding mechanisms, one of the most common choices for transitions today is the Multi Donor Trust Fund (MDTF):

“MDTF's are by far the most important coordination, harmonization and alignment vehicle in place” for post-crisis funding⁹⁹

Interviews with government and donor representatives (Southern Sudan, Afghanistan and Timor Leste) where MDTF's were established, also emphasised the significant fiscal leveraging capacity with opportunities for improved coordination and alignment with national plans.

Nevertheless, a review of post-crisis MDTF's commissioned by the World Bank¹⁰⁰ suggested a number of problems associated with these funding mechanisms. They can be politically risky for donors and governments alike if they fail to meet expectations or deliver highly visible 'short-term peace dividends'. Although most MDTF's have provision for national involvement, the dominant decision-making power on policy and funds allocations still resides with donors and the appointed fund administrator (e.g., World Bank).

Contrary to the principle of creating opportunities for capacity building through shadow alignment, the MDTF governance structure can potentially undermine efforts towards legitimising the nascent government and in practice can impose a high burden on central government¹⁰¹ (stewardship, administration and fiscal management). The human and financial resource costs of setting up and running the MDTF is high with complex fund administration. Furthermore, many MDTF's have a limited number of 'core donors' and so are vulnerable to policy shifts by these donors. Although considerable funds are invested in capacity development,

⁹⁸ Ibid.

⁹⁹ Scanteam Norway, (2007). *Review of post-crisis multi-donor trust funds, 2007*. WB and NORAD in cooperation with CIDA, Netherlands Ministry of Foreign Affairs and DFID.
<http://www.worldbank.org/rmc/cofdr/MDTFReportExecSum.pdf>

¹⁰⁰ Ibid. P.5

¹⁰¹ See case study : Key findings on MDTF's on South Sudan & Afghanistan” (Annex)

and claims are made for MDTF's strengthening the government's administrative capacity, there is no clear capacity development policy in any MDTF.¹⁰²

NGOs in Southern Sudan interviewed in a recent study,¹⁰³ expressed strong consensus that the MDTF is not the right aid instrument to deliver basic services in transitional settings due to a myriad of constraints including; structural, staffing and management issues. Fenton (2007) in her study of Southern Sudan aid mechanisms addresses the failure to involve NGOs and civil society sufficiently in the design, implementation and monitoring of the MDTF. NGOs feel that the impact of MDTF has largely been evaluated in terms of its contribution to harmonization, alignment and state building with negligible attention to its contribution to tangible benefits for the population. Disappointment over failure to deliver on peace dividends post-CPA has been voiced by government workers who recognize that the basic services are not reaching their communities on the scale promised. The flaw may well lie in the assumption that the MDTF has the capacity to address all of the basic service needs in Southern Sudan while attending to promoting national government capacities and stewardship.

Sector pooled funds are yet another variant on this mechanism and are deployed to streamline sector level resources. A decision to introduce a pooled funding mechanism for the health sector in Liberia was made by the MOHSW in 2007 following a participatory exploration of potential aid mechanisms. The rationale for this choice was based on two principle purposes in the current context: 1.) to increase alignment with government policy and plans, reinforcing the stewardship role of the MoHSW; 2.) to reduce the time and effort the Liberian government must spend managing multiple streams of support, reducing transaction costs and improving efficiency. Pool fund 'oversight' addresses concerns about premature provision of general budgetary support and provide satisfactory fiduciary risk assurances to potential contributing donors. The important role of DFID as lead donor, who contributed an initial \$8 Million USD, should not be underestimated. This pool funding is a possible interim step on the path to budget support. The lifespan of the pool fund will therefore be influenced by progress made towards financial transparency and governmental accountability. GoL aims to have made sufficient progress in strengthening their public financial management systems to qualify for direct budget support over the next two to three years.

To conclude, the different pooled funding mechanisms can enhance government stewardship and ownership as well as providing an opportunity to promote enhanced collaboration between all stakeholders in a transition. They can however be subject to bureaucratic delays which hinder the provision of basic services and the vital capacity building of fledgling health ministries. While it is acknowledged that the MDTF is not a panacea, the issue may be one of managing expectations regarding speed of delivery, ensuring complementary of other aid mechanisms, and overcoming the obstacles through accelerated financial and procurement procedures. Pooled funds are still relatively new as instruments in transitions but it is critical to recognise their potential as well as highlight the need for flexibility in how they are adopted and used.

¹⁰² Scanteam Norway, (2007). *Review of post-crisis multi-donor trust funds, 2007*

¹⁰³ Fenton, W. (2008). *Funding mechanisms in Southern Sudan; NGO perspectives*. Commissioned by Juba NGO forum.

iii. Global health initiatives

Global health initiatives¹⁰⁴ have gained momentum in terms of volume of aid and innovative approaches to addressing specific vertical diseases in the past decade. Most studies¹⁰⁵ agree that global health partnerships do provide large scale financing, mobilize expertise and knowledge management while also cultivating awareness of health issues at political levels. This leveraging capacity has raised unprecedented levels of public and private funding whereby combined aid volume for GFATM and GAVI account for 9% of global development assistance for health in 2007. This paper will focus on Global Fund for HIV, TB and Malaria (GFATM), to exemplify the major opportunities and threats posed by use of global health partnerships.

With specific attention to the transitional context, Global Fund (GFATM) reports that a total of \$1.79 billion has been approved to fragile states compared to an approx \$8.32billion overall. This accounts for 22% of funds approved, with 9% of the developing country population living in fragile states (World Bank 2007). Global Fund states that it does not distinguish between conflict and post-conflict states but is guided by the country based needs analysis and country capacity. Afghanistan, Sudan, Timor Leste, DRC and Sierra Leone are included in the fragile state global fund list, based on the Country Political and Institutional Assessment (CPIA) eligibility criteria.¹⁰⁶ As most donors adopt the CPIA to benchmark policy and institutional capacity of recipient governments, this has also become a determining factor in volume of aid allocated to transitional states.

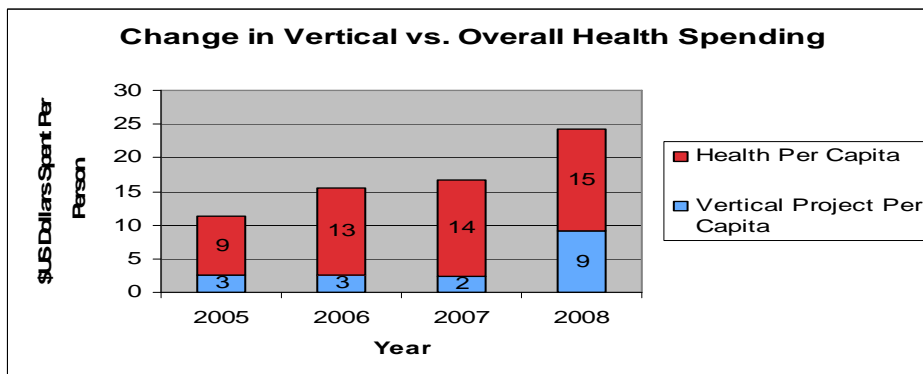
As demonstrated in virtually all of the countries studied, the Global Fund can bring significant finances to the health sector. In Liberia, there has been almost a quadrupling of funding for vertical projects from US \$8 million in 2005 to US \$29 million in 2008. As Figure 2 demonstrates, *per capita* spending on health services has increased from \$11 to \$24 *per capita* from 2005 to 2008 mainly due to an inflow of vertical project funding.

¹⁰⁴ Blanchett, K. (2007). *Global Health partnerships and initiatives; Meeting the MDG's*.

¹⁰⁵ Caines, K. (2005). Key evidence from major studies of selected Global health partnerships. DFID HRC.

¹⁰⁶ The Country Political and Institutional Assessment (CPIA) is a comprehensive index of both institutional and policy capacities for all developing countries developed by the World Bank and used by multilateral and bilateral donors to inform aid allocation. (There is a new index for FS Post-Conflict Performance Indicators (PCPI) – see [website](#)).

Figure 2: Change in Vertical vs. Overall Health Spending in Liberia, 2005-08



Major sources of health funding, including GoL but excluding out of pocket payments

With 65% of vertical project funding allocated to malaria control in 2008, it can be argued that additional health resources are being targeted at traditionally leading causes of morbidity and mortality in sub-Saharan Africa.¹⁰⁷ However, key informants raised important questions about the 23% of vertical funding allocated to HIV as prevalence is considered low¹⁰⁸ according to the preliminary findings of the 2007 DHS, and funds are said to be spent more on treatment rather than prevention.

The DRC Health Systems Strengthening Strategy (2006) based on the decentralized development of health zones (HZs) is critical of disease specific programs and associated global fund mechanisms. It advocates for integration of all vertical interventions into the minimum package of services delivered by the health system. Such sentiments are also articulated by Southern Sudan MoH who has encountered the fragmentation of HIV/AIDs programming. More recent efforts have been made to reinforce integration and mainstream health system support for HIV/AIDS with financing from the MDTF (2007) through the design of an integrated planning framework.

In terms of institutional arrangements, findings across the spectrum of countries show that Global Fund presents major challenges to nascent governments due to (i) the potential to create separate mechanisms for funding and delivery, (ii) the complexity of applications and implementing procedures with (iii) labour intensive monitoring processes. Program efforts should be calibrated to country contexts taking into account the specific political and policy environments¹⁰⁹ while avoiding competition for limited national resources to respond to national priorities.

¹⁰⁷ The vertical project funding included is GFATM & PMI. Clearly delineated health system strengthening (HSS) makes up less than 10% of the vertical funding indicated; however, Liberia will submit for HSS under GFATM Round 8 for HIV.

¹⁰⁸ Less than 2% of the more than 17,300 men and women aged between 15-49 were tested HIV positive, confirming a low rate as found in the 2006 ANC sentinel surveillance which found a prevalence rate of 5, 7% thought to be higher mainly due to sites being located in more urban areas.

¹⁰⁹ *Fighting AIDS, TB and Malaria in fragile states; does Global Fund model of engagement answer the question.* (2006) (LSHTM MSc Thesis)

In responding to the challenges cited, Global Fund reported¹¹⁰ that they advocate for government to assume the leadership role as Principal Recipients (PR's). They also welcome the principles of (i) public private partnerships between government and CSOs (ii) provision for capacity building as integral with all projects and (iii) they advocate for at least 15% contribution per project towards dedicated health systems strengthening.

NGO representatives interviews counter argue that;

“It is great that Global Fund is provided to fragile states but it has limited and narrow funding lines, usually drugs, curative care with limited scope for preventive services and virtually no health system strengthening” (NGO spokesperson).

With reference to the use of global health initiatives in transitions, concerns raised include the balance of resource investment for vertical and integrated health programming, arguing that global health initiatives may undermine reconstruction of a new health system. The proliferation of additional structures and systems to serve the delivery of vertical programs has created new layers of bureaucracy and added to the complex aid architecture that emerging governments in post-conflict countries have to grapple with. Attention needs to be given to this to ensure the funds will have a positive impact in such countries where currently 22% of Global Funds are allocated.

iv. Direct budget support

While budget support and debt relief are modalities which inculcate alignment to government systems, donors are often hesitant to adopt them, due to concerns over weak financial systems, corruption and related weak accountability. In the context of post-conflict transitions, the proportion of budget support is relatively low, with a recent survey indicating direct budget support aggregate for post-conflict countries in Africa as 20-25%¹¹¹. There is a distinct preference in transitions for project aid or intermediate modalities such as pooled funds or basket funds which implies shared risk among donors and enhanced control over allocation of resources¹¹². Some donors are bound by state avoidance regulations which can be even more amplified in fragile contexts when direct budget support is not an option, with strong preference for contracts to private providers. In post-conflict countries there is also a need to provide ‘peace dividends’ or visible efforts from a government to build its perceived legitimacy, and overall policy and institutional quality through complementary technical cooperation.¹¹³

DFID deployed budget support mechanisms in Sierra Leone which enabled rapid transfer of resources in the critical post emergency period. This arguably contributed to post-conflict recovery through enhancing the legitimacy of government, sustaining peace and provision of resources for basic services, i.e.

¹¹⁰ Interview with Global Fund Manager (Geneva) – March 2008.

¹¹¹ Survey by Strategic Partnership with Africa (SPA) cited in Agha and Williamson (2008). *Common funds for sector support*. (ODI Briefing paper)

¹¹² Agha, Z. Williamson, T. (2008) *Common funds for sector support*. ODI Briefing paper.

¹¹³ Leader, N. Colenso, P. *ibid*.

salaries for health staff.¹¹⁴ It is recognised though that this needs to be accompanied with system strengthening at sector and national level to mitigate risks. By 2008, at least 40% of total international aid to Sierra Leone is channelled via direct budget support in Sierra Leone despite the challenge of fiduciary risk for donors. Further study into the impact of this approach is recommended.

Direct budget support (general or sector) shifts the focus of aid to country systems and policy processes, thereby empowering national governments and transition administration to improve policies and budgets. Donors also recognise the opportunity to reduce the transaction costs of aid¹¹⁵ and the fact that it enables recipient countries' governments to align aid allocation to the implementation of their national priorities. However, donors' commitment for budget support is very limited, often constrained by conditionality such as solid public spending mechanisms in place at the recipient country level, adherence to basic human rights, and strong commitment to reducing poverty¹¹⁶.

vi. Technical Assistance

Technical Assistance (TA) is used in many transitional settings and is an important adjunct to budget support and other aid instruments. There are multiple forms of technical assistance in operation but invariably insufficient for the purpose of building the core capacities of new central and peripheral systems in a country where even the most rudimentary systems are decimated. Within the MOH, the technical assistance tends to be more ad hoc and reliant on various donors supporting advisors for health systems strengthening and vertical programs. Afghanistan Ministry of Health have received significant technical assistance from the major donors in support to contracting and delivery of the provincial basic package of services. In contrast, DRC experiences fragmentation in technical assistance due to the complexity of the system; over 52 program offices located within the MOH, presents a major challenge to capacity building for a decentralized health zone system. Some donors have shifted the locus of support to the provincial and health zone level to support the semi-autonomous management at local level. Southern Sudan faced the dilemma of delays in awarding of contracts to private providers through MDTF funding which resulted in a major vacuum in technical support during the critical early stages of the transition. In Liberia, the Clinton Foundation provide several technical experts as advisors to the MoHSW in Liberia, while specifically focusing on HIV, they have provided significant support to the MoHSW in other areas by filling gaps in capacity building identified by the Ministry, sometimes as a result of delays in assistance planned to be provided through other projects.

Interviewees were consistent in highlighting the need to maintain health service coverage for vulnerable populations while introducing technical assistance for institutional capacity building requires a balancing of priorities between short term objectives and longer term needs. But technical assistance should not wait until the

¹¹⁴ Interview with donor representative (Sierra Leone). March 2008.

¹¹⁵ Eifert B. Gelb A. 2005. *Improving the Dynamics of Aid: Towards More Predictable Budget Support*. Policy Research Working Paper No. 3732. Washington: World Bank.

¹¹⁶ Cordella T. Dell'Ariccia G. 2003. *Budget Support versus Project Aid*. IMF Working Paper No. 03/88, Washington: International Monetary Fund

peace treaty is signed, TA to governments is required at the pre-planning phase to assist in conceptualization of recovery strategies and choice of preferred aid modalities with capacity building support integrated and mainstreamed rather than stand alone project support.

The gaps in technical capacity in new ministries requires urgent external technical support from the onset, as delays can negatively influence the efficiency of planning and delivery of health services which in turn affects the effectiveness of aid. Where TA was provided (Timor Leste, Afghanistan), the MOH have acknowledged the invaluable contribution to management capacity. However, the risks of reliance on TA's over the longer term and a continued awareness of fostering national ownership have been highlighted.