Report for DFID

Service Delivery In Countries Emerging From Conflict.

Final Report
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EXECUTIVE SUMMARY

The aim of this report is to examine service delivery in countries emerging from conflict from two perspectives:

- the strategic role of service delivery in promoting social and political pro-poor change towards the avoidance of future conflict and strengthening institutions in countries emerging from conflict;
- appropriate and sustainable service delivery systems in countries emerging from conflict.

Commissioned by the Service Delivery In Difficult Environments (SDDE) team at the Department for International Development, the report is based on evidence and experience from four SDDE-selected case studies of Mozambique, Uganda, Cambodia and East Timor, as well as other post-conflict countries and lessons learned experiences. It also draws on a review of the formal literature and further analysis derived from the 'grey' literature and practical experience.

The fist section develops a framework for examining evidence arising from the case studies. Summarising current thinking about the relationship between violent conflict and development, the review understands 'the avoidance of future conflict' as managing conflict from a development perspective, rather than promoting unjust and unsustainable peace. Through consideration of methodologies for integrating conflict management into development strategies, including the DFID methodology of Strategic Conflict Assessment, the review proposes tools for examining the relationship between service delivery and violent conflict, showing how these change or may change over time. In Section Two, these tools are employed to consider the role of service delivery in different 'phases' of conflict within the case study countries. Section Three considers the implications of the case studies and wider policy review and field experience for good practice. Section Four summarises the review's principal findings and recommendations. Each of the four case studies is annexed to the main report.

Delivery of services, such as health and education, can play an important role in preventing conflict or exacerbating it. Distribution of resources and their accessibility by or deliberate denial to different groups may either address or heighten existing social inequalities. Equity and inclusiveness are critical issues, as well as indicators, for those seeking to ensure service delivery promotes sustainable peace. Yet the case studies revealed that rarely has peacebuilding been an explicit objective of interventions. While the review records the pattern of responses and potential indicators of success, it thus proved extremely difficult to accurately gauge the effectiveness and impact of service delivery response. The review has, however, been able to identify a number of major issues for maximising the capacity of service delivery to promote sustainable peace. These include the need for:

Strategic Analysis and an Integrated Approach

In seeking to explore how interventions responded to the evolving situation and identify the impact of service delivery on conflict and promoting peace, the review has employed a model which considers the interventions of a range of actors through the delineation of four 'notional' phases of conflict – ongoing conflict/pre-agreement; peace agreement; recovery; and reconstruction. It clearly recognises, however, that conflict presents no such discrete delineation and violent conflict continued in areas of the case study countries following a peace agreement/settlement, making questionable their inclusion among 'countries emerging from conflict'.

When set against an analysis of the principal causes and actors of conflict, the mapping of service delivery response does clearly highlight the need for strategic analysis in relation to a specific

context and that there is no set appropriate response. Moreover, the views of actors towards service delivery can be seen as important indicators of their prioritisation of policies which are pro-poor and supportive of long-term peace.

The review further highlighted the difficulty of focusing on service delivery in isolation of the wider context and the need for care in placing excessive weight on service delivery as a decisive factor in conflict and development. Even where education services were reconstructed, children in Mozambique did not go to school where they were needed to rebuild livelihoods. This underlines the need for an integrated approach and for all forms of intervention to be based on an overarching strategy.

Early Engagement

While there are opportunities for peacebuilding at all phases of conflict, the case studies highlighted the lasting impact of early engagement both to sustain people during conflict and to strengthen capacity for subsequent transition. Early engagement also allows donors to reach a closer understanding of underlying issues and national capacities, enabling them to move forward quickly when peace comes. In Mozambique and East Timor, major policy changes were charted out with the future government before the end of war and implemented rapidly once peace was declared. Supported by the WHO and the World Bank, the Mozambican Ministry of Health established an information base and health policy even before the official peace agreement was signed. Similarly in East Timor, the early engagement of the World Bank was critical in opening the way for reformist pro-poor policies, notably in primary education.

Provision of education services to those displaced by conflict can also play an important contribution to strengthening capacity for reconstruction. Health staff trained in emergency humanitarian assistance programmes in Mozambique strengthened national capacity to restore services after the peace agreements. Similarly, health staff trained in refugee camps in the Thai/Cambodia border proved a valuable asset in the reconstruction of Cambodia's health sector, particularly after the massacre of health professionals under the Khmer Rouge regime. It remains unclear, however, whether these were the explicit objective of the donors, which supported these interventions.

Service Delivery as a Bridge for Peace:
Supporting Equitable Distribution of and Access to Resources

While donors may be keen to support more readily recognised peacebuilding programmes, such as electoral processes, within countries emerging from conflict, such support can leave unresolved deeper issues of social inequality. Services in the case study countries have been used as a 'bridge for peace'. In Mozambique, NGO extension of food distribution and health provision across the lines of conflict, into areas to which there was previously restricted access, played an important role in decreasing tensions and dismantling military control on movement. In an attempt to tackle pre-existing imbalances in service provision, initial reconstruction was focused on rural areas and less privileged communities. NGOs were allowed to revive health service in RENAMO-controlled areas and retraining of health staff from RENAMO areas demonstrated government willingness to build peace and opening the way the progressive reintegration of rebel areas within a common administration. In Cambodia, the WHO supported the Coordinating Committee for Health's efforts to reintegrate health workers from three of the four principal factions within the interim health administration, in advance of the internationally mandated government. However, international agencies and NGOs remained reluctant to engage with the Committee, due to its association with the questionable transitional government.

Restoration or Reformation: Legitimacy and Sustainability

Expectations in the immediate period around a peace agreement or settlement are high amongst both the national population and donor governments. With service delivery programmes generally run through the state, or at least involve its strong engagement, service delivery interventions touch directly on issues of legitimacy. Recognising this, governments in countries emerging from conflict have to balance directing limited available capacity towards tangible peace dividends and the development of systems sustainable in the longer term. Yet, the window for introducing radical pro-poor change is often open only briefly and failure to grasp it early has significant long-term impact on the poorest. While the Ugandan government recognised the reach demonstrated by vertical programmes, such as the Expanded Programme of Immunisation, its initial focus on restoration of pre-conflict services failed to address their longer-term unsustainability. The government failed to prioritise social development within the country's reconstruction and recovery programmes, assuming this would follow in the wake of economic recovery. Yet once donors withdrew their support for the recurrent costs of primary health care in poor areas, utilization of public services diminished.

Focusing on Social Policy Framework

Low absorptive capacity within nascent government ministries may be coupled with donor reticence to engage directly with the structures of the government whose legitimacy is in question. While donors are keen to focus on the direct consequences of war, especially reconstruction of the physical infrastructure, they tend to 'wait and see' when it comes to direct support to social service line ministries. The case studies indicate that the most effective responses have been those which supported a credible state. The early development of health policy in Mozambique enabled the government to, at least with those donors willing to coordinate, provide a policy framework to support equitable service provision. Similarly, the early formation of the East Timorese Health Professionals Working Group, and subsequent Interim Health Authority, enabled a health sector rehabilitation and development programme, clarifying the role of international NGOs in providing emergency services freeing up national capacity to focus on developing longer term policy. ECHO promoted international NGO collaboration with the Interim Health Authority, agreeing standard levels for certain health expenditures. The development of a coordinated framework for social policy proved much more problematic in Cambodia after the peace agreement because of the questioned legitimacy of the transitional government. The lack of a legitimate coherent national framework led to a disproportionate focus of support around the capital and in the northwest, while the US and European donors directed aid according to political criteria rather than on the basis of need. Indeed, direct donor negotiation with non-communist factions jeopardised the 1991 Peace Accords and the mandate of the UN Transitional Authority in Cambodia.

Building Capacity and Flexibility on Budget Support

The case studies confirm the critical role of the state, especially in the period surrounding peace, when it is vital to restore governing capacities. Yet the depletion of technical capacity during conflict is not quickly redressed. In this period, budgetary support for salaries and training of staff in the health and education sectors may be appropriate, despite the risks associated with weak financial oversight and caution in legitimising a government through engagement with public sector ministries. For example, the Swiss Development Cooperation-provided budget support to the Mozambican Ministry of Health prior to the 1992 agreement not only enabled the expansion of services, but strengthened information system to enable the monitoring of reconstruction. It is, however, clear that weak constitutional and legal checks can facilitate political and criminal elite

capture of uninformed external support. Yet few donors focus on corruption, despite this being vital to building sustainable pro-poor change.

The case studies moreover revealed that the levels of aid and timetables for spending often reflected political considerations as opposed to being based on an appraisal of need. Even in Mozambique, where the response was more coordinated than in the other case study countries, individual donor priorities in some cases promoted rehabilitation projects lacking exit strategies, which would ensure their sustainability. Similarly, the complexity of donor aid to East Timor's reconstruction inhibited national ownership and prevented the integration of all funding sources into the national budget.

Representing the Poor and Empowering Women

Service delivery can play a vital role in providing a channel for strengthened representation of poor people through user groups, parents associations and civil society organisations. Civil society can represent the interests of poorer people in national processes such as the development of Poverty Reduction Strategy Papers. However, civil society will need to remain truly representative and accountable. The establishment of such bodies and channels for engagement of the poor in decisions, which directly affect them, takes time, particularly during times when people are most concerned in meeting their immediate needs. This is particularly the case for women, who usually have prime responsibility for child care and the strongest interest in delivery of services, but who may be under-represented in user groups and parents' associations. While people were enthusiastic about peace in East Timor, public participation was low. Although demonstrating government prioritisation of those most in need, centrally-imposed programmes to promote local involvement in East Timor proved unsustainable and, in some cases, susceptible to domination by local elites. Similarly, the state-designed efforts to promote decentralisation in Cambodia proved less successful than the later UNDP support for local management of rural development. Uganda has, however, been successful in promoting local monitoring through user groups. Through a mass information campaign by central government, schools and parents were enabled to monitor local expenditure of education grants, resulting in large drops in leakages.

Harness Non-state Actors within a Regulatory Framework

In an effort to reduce high levels of aid dependency and inappropriate patterns of provision, donors have turned to non-state actors where government capacity has been weak or untrustworthy. Despite unclear results from pilot schemes, some donors are keen to further extend contract systems. Choices between state and non-state actors need to reflect the interests of poor people, both in the short and long-term, based on wider strategic analysis. Systems of public accountability are required whether services are contracted out or not and, where service delivery is privatised, the state will need to ensure socially responsible regulation.

Conclusion

The review makes clear that service delivery interventions directly impact on conflict. To promote sustainable peacebuilding, interventions need to be developed through ongoing strategic analysis of the causes of and actors in conflict and development. Such deliberate analysis also enables the identification of indicators to more accurately gauge the positive and negative impact of the support provided. It is clear that early government prioritisation of and commitment to policy reform and allocation of resources for service delivery are critical to development actors. Reformation of services as countries emerge from conflict provide important opportunities for ensuring the representation of poor people in the formation of service delivery policy, together with strengthening local ownership of these services through ongoing monitoring.

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ACRONYMS

BWI	Breton Woods Institutions
CDR	Community Driven Reconstruction
CFET	Consolidated Fund for East Timor
CICS	Centre for International Cooperation and Security, University of Bradford
CNRT	Conselho National da Resistencia Timorese
CoCom	Coordinating Committee for Health (Cambodia)
CPRU	Conflict Prevention and Reconstruction Unit, World Bank
ECHO	European Community Humanitarian Office
EPI	Expanded Programme of Immunisation
HIPC	Highly Indebted Poor Country (World Bank/International Monetary Fund)
IHA	Interim Health Authority (East Timor)
INGOs	International Non-governmental Organisations
InterFET	International Forces in East Timor
LNGOs	Local Non-governmental Organisations
LRA	Lord's Resistance Army
MDG's	Millennium Development Goals
MOH	Ministry of Health
NRA	National Resistance Army
NRM	National Resistance Movement
ONUMOZ	UN Operations in Mozambique
PRA	Participatory Rural/Rapid Appraisal
PRSP	Poverty Reduction Strategy Papers
QUIPs	Quick Impact Projects
SAP	Structural Adjustment Programme
SCA	Strategic Conflict Assessment (DFID)
SC UK	Save the Children UK
SOC	State of Cambodia
SNC	Supreme National Council (Cambodia)
SSR	Security Sector Reform
SWAP	Sector-Wide Approach
TAC	Technical Advisory Committee (Cambodia)
TFET	Trust Fund for East Timor
UNAMET	United Nations Assistance Mission in East Timor
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNMISET	United Nations Mission in Support of East Timor
UNOHAC	United Nations Office for Humanitarian Assistance Coordination (Mozambique)
UNTAC	United Nations Transitional Authority in Cambodia
UNTAET	United Nations Transitional Administration for East Timor

FULL REPORT

Service Delivery in Countries Emerging from Conflict

Introduction

Terms of reference. This report was commissioned by the Service Delivery in Difficult Environments (SSDE) team at DFID whose overall purpose is to:

> *'…produce guidance on mechanisms and levers for service delivery in difficult environments that facilitates the creation of coherent institutional arrangements and promotes social and political pro-poor change.'*

The report focuses on lesson-learning and the identification of key approaches and considerations for audiences in DFID regional and country teams, other policy division teams, and other bilateral and multilateral partners. It is based on four case studies (Cambodia, East Timor, Mozambique and Uganda) and a general review of the academic and 'grey' literature. We have also drawn on other work for the SDDE team such as the literature review by DFID Health Systems Resource Centre.

The consultants were requested to examine service delivery in countries emerging from conflict from two perspectives:

- the *strategic role* of service delivery in promoting social and political pro-poor change towards the avoidance of future conflict and strengthening institutions in countries emerging from conflict; and
- strengthening sustainable service delivery *systems* in countries emerging from conflict.

The report was written by Tony Vaux and Emma Visman, two consultants appointed by the Centre for International Cooperation and Security (CICS) at the University of Bradford. Earlier drafts have benefited from discussion with DFID, including a workshop in London on 2 August 2004. The Bradford team gratefully acknowledges input from a wider team of readers and experts, including Margaret Sinclair, John Walley, Enrico Pavignani, Susan Nicolai, Andrew Timpson, Chris Talbot, Peter Poore, Joseph Hanlon, Ann Robins, Chris Eldridge and Sobhi Tawil. The work of Joanna Macrae and her colleagues at ODI has also been strongly influential.

Definitions. "Countries emerging from conflict" means those countries in which there is a reasonable expectation of peace, or an actual peace agreement. By implication we are not so much concerned with ongoing conflicts, failed states or complex political emergencies. The definition involves an element of subjectivity regarding the future direction. Likewise, other related terms and concepts relate to various aspects and issues of this phenomenon.[1]

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[1] Within the context of this report, we define certain terms as follows:

"Conflict" is a natural part of human discourse and, in itself, is not necessarily negative or destructive. Problems arise when individuals, groups and/or communities abandon peaceful or constructive conflict management strategies and instead resort to the use of violence and intimidation to resolve differences.

"Violent Conflict" results in personal injury or death and/or physical property damage in a dispute.

"Peace" implies more than the absence of violent conflict and/or the threat of intimidation. It involves individuals and communities practicing constructive conflict management strategies to resolve disputes.

In this report, we have adopted the following definition of the term 'Service Delivery' as used by the SDDE Team:

> **The Meaning of Service Delivery:**
> Service Delivery is conceptualised as the relationship between policy makers, service providers, and poor people. It encompasses services and their supporting systems that are typically regarded as a state responsibility. These include social services (primary education and basic health services), infrastructure (water and sanitation, roads and bridges) and services that promote personal security (justice, police). Pro-poor service delivery refers to interventions that maximise the access and participation of the poor by strengthening the relationships between policy makers, providers, and service users.'
>
> "Approaches to Improving the Delivery of Social Services in Difficult Environments," PRDE WP 3 (October, 2004), SDDE Team, DFID.

The inclusion of the phrase 'towards the avoidance of future conflict' has caused us considerable difficulty. While it is generally true that the avoidance of future conflict is a means towards development objectives, DFID's overall aim would be confused if it pursued both peace and development as absolutes. Which would take priority at different times? We base our analysis on the view that peace is a slippery concept and is not desirable at all costs, especially if it means the perpetuation of poverty. Although encouraged to do so, we express a caution about the process of dividing conflict into discreet 'phases'. This may be useful as a rough guide, but can easily lead to oversimplifications and misconceptions. Today's conflicts are often cyclical and the underlying causes are likely to persist even after a peace agreement is reached. Peace is not necessarily the same as the absence or avoidance of violent conflict.

A final caveat regarding this report is that three of the four case studies selected by DFID are perhaps somewhat unusual in that conflict was ended because of geo-political changes heavily endorsed by the international community and in each case involving what could be called an external aggressor. The fourth case, Uganda, is perhaps more typical - an internal struggle temporarily halted by a kind of uneasy truce that does not tackle the underlying internal problems. Afghanistan, Sierra Leone and Sudan would be examples of other such cases where the internal tensions make peace agreements fragile to say the least.

Structure of the report. Section one summarizes current thinking about the relationship between violent conflict and development and the methodologies for integrating conflict management into development strategies. Based on the DFID methodology of Strategic Conflict Assessment, tools were developed for examining the relationship between service delivery and violent conflict and showing how these change or may change over time. Section two looks at the case studies in relation to different 'phases' of conflict and make general observations about the quality of the responses. Section three considers the implications of our case studies and literature review for good practice. Section Four offers conclusions from the study and recommendations to DFID.

Our four case studies are attached as Annexes: (1) Cambodia; (2) East Timor; (3) Mozambique; and (4) Uganda.

"Peacebuilding" is a process which consists of two parts: (i) the construction of the structures of peace, and (ii) the de-construction of the structures of violence. It is not about the imposition of externally defined solutions, but rather the creation of a space within which indigenous actors (parties to the conflict) can identify problems and formulate their own solutions.

SECTION ONE: Conflict and Service Delivery

1.0. Introduction

Violent conflict is commonly analyzed in relation to security and political issues. It is viewed as a clash of military forces and political entities. Our concern as development agencies is to focus more sharply on the social and economic spheres while recognising that these interact with security and political issues. Today's conflicts occur most commonly in the poorest countries. Among their causes are factors relating to poverty, and they have their most devastating impact on marginalised and vulnerable populations.

Analysts recognise that such violent conflicts often manifest themselves as struggles for economic resources and political power. In the process, people are mobilized around grievances that often relate to access to services such as water, health, sanitation and education. Although such issues may receive less attention, service delivery is closely associated with conflict and may be one of the main causative factors in the minds of certain combatants. When a country emerges from conflict, and the combatants are no longer occupied with fighting, these underlying grievances may emerge again as essential elements of the peace.

This means that development is closely associated with conflict and may do harm as well as good. Providing essential services at the time of peace may help to cement a political agreement. Providing it in a specific area may send a political message about inclusion and exclusion. Mistakes and spoilers could threaten the peace, but well-thought out strategies could contribute positively.

For humanitarian actors the principle of 'Do no harm' may be adequate because they aim to do no more than relieve the symptoms. However, for development actors trying to achieve the MDG's, there is an obligation to transform the situation in a pro-poor direction. They have the capacity to influence fundamental factors such as governance, while conflict creates a fluidity in which it may be unusually possible to achieve pro-poor change.

Therefore, the objective for those engaged in service delivery is not to avoid or ignore conflict but to integrate it into their development strategies. At a time when countries are emerging from conflict, the underlying economic and social factors are likely to become more tractable and also more important. This presents considerable challenges to development agencies both in terms of conceptualizing conflict and in terms of strategy. There are a number of very difficult questions to be answered. To what extent does reducing conflict become an objective in itself? Should aid donors be engaging in explicit peacemaking activities or is that more the preserve of diplomatic and military actors?

Service delivery involves some particularly difficult questions. Since such programmes are generally run through the state, or at least involve its strong engagement, there may be questions of legitimacy. This is likely to be the case in a civil war. The state may seek to use service delivery as a way of winning hearts and minds, or it may seek to deny such services to sections of the population that it considers troublesome. A characteristic of service delivery is that it takes development right out to the people. Health centres and water-points can reach remote areas where power stations and factories do not. Some recent studies indicate that lack of services contributes to the phenomenon of alienated youth that is commonly recorded as a major factor in

conflict[2]. We cannot assume that such factors will always be crucial in a conflict, but they are likely to be of some importance depending on the situation. Whatever development actors do alters the dynamic of conflict, even if only in small ways.

As a general rule it is better to promote peace rather than conflict, but in some cases this is not so obvious. Donor governments are not necessarily pacifist and may not necessarily expect their aid departments to be pacifist either. The 'peace' of Saddam Hussein's Iraq was shattered by Western forces. The 'peace' of Rwanda was shattered by a genocide that revealed appalling tensions and inequalities in which aid agencies were deeply implicated[3]. Throughout Africa, evil regimes have been toppled through conflict and violence –sometimes to the benefit of poor people.

Some commentators go further and argue that turbulence may be the natural state in some areas of the world where economic marginalization makes it impossible to have strong state structures and where the only chance of gain is through tax evasion, illegal actions and exploiting opportunities in the wealthier Western states. It has been argued that this turbulence in the 'borderlands' is the inevitable consequence of wealth and peace in the West[4] in much the same way that a rich city quickly attracts slums and underworld activity.

The causes of conflict may thus go far beyond the stresses and strains of a particular country. What may manifest as a struggle between ethnic groups may have its origins in exclusive Western development and trade arrangements that deprived a group of its traditional income and set them at odds with their neighbours. Climate change caused by emissions from the richer states may flood the land of poor people, forcing them into conflict with more fortunate neighbours.

In this report we will not assume that all aspects of conflict are negative, but instead that the objective is to manage conflict from a development perspective. Otherwise, words such as 'peace' and 'conflict' would become meaningless. The main basis of this report is the four case studies, but in this first Section we will first describe how international aid agencies have grappled with such issues since the end of the Cold War and what methodologies have been developed to help aid managers.

1.1 Conflict and development

The Carnegie Commission's Report on Preventing Deadly Conflict[5] and the OECD-DAC Guidelines on Peace, Conflict and Development Cooperation[6], marked major shifts towards the understanding of conflict as an inextricable part of development. Conflict of the type that plagues the world's poorer countries was recognised not only as a complex interaction of different factors, but also as a dynamic process directed by the interests of powerful actors[7]. The concerns and aspirations of poor people very often become embroiled in these struggles between elites. They are only rarely the main issue at stake, but the involvement of poor people in fighting may give them an opportunity to assert their interests and bring about change.

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[2] See for example- Richards (1996)
[3] Uvin (1999)
[4] Duffield (2002)
[5] Carnegie Commission on Preventing Deadly Conflict (1997)
[6] OECD/DAC (1997)
[7] Keen (1994)

In the course of time the underlying causes of a protracted conflict may be aggravated by other factors that arise during the conflict. Eventually the conflict may seem to revolve around nothing but itself; it becomes little more than a series of attacks based on revenge and ingrained hatreds. There may come a time when the only way to stop such a conflict is through external military force or the victory of one side over the other. Yet, as the conflict deepens, the various underlying causes and issues will again become more important. Development inputs may be particularly crucial in securing a peace.

A further shift in the understanding of conflict by aid agencies has been the acknowledgement that conflict could be in the interests of poor people or, at the very least, present them with opportunities as well as threats. A decade ago it was common for aid agencies to treat conflict as an obstacle and peace as an absolute and immediate goal, whereas today they are more inclined to view conflict as a symptom of tensions and changes in society that may be intimately connected with development processes. Conflict is not an ideal way of achieving change and violent conflict can be very destructive, but this does not mean that it is in opposition to developmental objectives. This understanding has been reflected in the basis for the UK's Global Conflict Prevention Pool. Accordingly,

> '*The UK government recognises that elements of conflict are an essential part of all social and political change, so eradicating conflict altogether is an unrealistic goal.'* [8]

This is not to deny that war has its most devastating impacts on poor people. Unable to hire private security, move to another place or resist pressures to enlist, poor people often experience a large proportion of the violence without achieving any benefits at the end of the process. Peace may mean little more than a shift in power between elite groups that have no serious interest in development. Violent conflict has particularly negative long-term consequences for women, often leading to erosion of their status as society becomes more militarized and violence spreads. Although women sometimes gain access to a wider range of occupations during war, these gains are often wiped out by social reaction and the reinstatement of repressive 'cultural' norms.

Most recently the trend in donor thinking has tended to move back towards treating conflict as harmful in itself. This results largely from a concern among Western states, following the Global War on Terror (GWOT), to treat global security as a prerequisite for Western security. Commentators have begun to express concern that Western security is taking precedence over development interests in the allocation of aid[9]. Depending on whether a conflict is perceived as a threat to the development of local people or to global peace, reactions can be quite different. Where Western governments take sides in such a conflict, the role of external aid becomes especially problematic as political interests infringe upon the neutrality of assistance. Humanitarian agencies will be particularly concerned to guard their impartiality in the delivery of assistance based upon need alone. The safety of vulnerable populations, the security of staff as well as the relations with affected populations may become contentious issues.

This makes it especially important for donor agencies to base their activities on objective judgements. They need to take account of a wide range of regional and international influences especially the political and security interests of their own government. While we may wish to focus on relatively local issues, we can only do so today after taking account of much more.

[8] DFID, FCO and MOD (2003) p5
[9] Christian Aid (2004)

1.2. Service Delivery in relation to conflict

Sustainable development can be a means of preventing violent conflict, addressing underlying issues during the course of conflict and addressing root causes in the process of recovery. Services such as health and education can play an important role in preventing conflict or in exacerbating it. For example, the most common and probably most serious issue for aid managers is the distribution of resources. The provision of water and sanitation to one community could lead to tensions and resentments in another. International Alert has documented a particularly stark example from Burundi where aid for education has benefited one group, creating grievances among the others and fuelling the ongoing conflict.[10]

DFID's Issues Paper on "Education, Conflict and International Development"[11] documents many other such cases. The Paper draws attention to the "two faces" of education. Education can play a positive role through appropriate curriculum and good distribution of services, but equally can contribute to conflict if schools are used as places where hatreds are encouraged or if access to education follows patterns of injustice and exclusion. The Paper also acknowledges that the process can become a vicious circle. Sschools may be targeted in an effort to undermine government legitimacy and then their destruction could lead to an increase in the number of alienated youth unable to participate in society and drawn into crime and violence.

While delivery of health and water services will usually have a positive impact, there may be critical questions about the distribution of such services and their accessibility by different groups. The provision of water points in a village can easily lead to the reinforcement of social tensions. The site for a well must take careful account of cultural and social divisions especially for vulnerable women and girls. Water points for pastoralists in the Sahel are a common source of tension among farmers and have been known to cause violent clashes. In northern Nigeria they have been implicated in wider conflicts between ethnic groups.

Despite these dangers, service delivery generally has a positive tendency in relation to conflict. It can be part of the 'peace dividend' and reinforce the peace especially through Quick Impact Projects. If local people are engaged in planning and decision-making, the positive impacts will be further increased. Targeted towards alienated groups, the process can be still more beneficial. However, this does involve 'taking sides' or, at the very least, making judgments about the nature and causes of conflict. This makes it essential that such actions should be based on thorough analysis.

1.3. Analyzing Conflict

The OECD -DAC Guidelines on Peace, Conflict and Development Cooperation of 1997 included an early attempt to identify the critical questions for aid agencies engaged in such situations. DFID has since been at the forefront of developing methodologies to increase understanding of the relationship between development and violent conflict. Research commissioned by DFID concluded that conflict should be integrated into development processes at the strategic level.[12] It was not enough to make small adjustments to programmes in order to make them 'conflict-sensitive'. The choice of programmes, policies and operating locations could all have an important impact on conflict. The research also indicated that it was unwise to respond to conflict simply by adding some, "conflict-related work" to the overall programme. This should not be a substitute for rethinking overall strategy in relation to conflict.

[10] Jackson.
[11] Smith and Vaux (2003)
[12] Goodhand (2001)

The result of this research was the methodology for Strategic Conflict Assessments (SCA) published by DFID in 2002.[13] It has been used as the basis for a number of country-level studies that have sometimes included new sets of programmes or 'Peace-building Frameworks'. In Nepal and Nigeria, a full SCA formed the basis for a review of DFID programmes from a conflict perspective. In both cases, this resulted in significant changes. In Nepal, for example, DFID re-aligned its human resources strategy to take into account the marginalization of certain groups.

	Security	Political	Economic	Social
International	*Peacekeepers not involved in protection*	*Donors focused on structures not policies*	*Debt repayments reduce budget*	*Limited international NGOs in education*
National	*Negative perceptions of the military*	*Policies based on exclusion*	*Weak policies for marginal areas*	*No legal control on discrimination*
Local	*Limited protection of children going to school*	*Limited representation of poor people*	*Curriculum not oriented to employment*	*History curriculum offends some groups*

Table 1: Causes of conflict in Nepal (abridged)

DFID's methodology has formed the basis for similar work by UNDP (Conflict-related Development Analysis) and for NGOs such as ActionAid and Tearfund, which have developed the DFID system into a Human Security Framework. The World Bank has developed a similar system, the Conflict Analysis Framework. The essential characteristic of all these tools is that they focus on a broad review of development strategy rather than on tactical ways of working in conflict situations. However, their impact has been limited. Donors rarely integrate such analysis into their wider strategy, but tend instead to use it for shaping particular programmes.[14]

The SCA methodology is appropriate for use by aid managers in countries emerging from conflict. Even a brief participatory process with key stakeholders would produce a multi-dimensional map of conflict on which it would be possible to track developmental objectives. This may be presented as a general matrix for analyzing conflict, based on the DFID methodology-

Table 2: Causes of conflict matrix

	Security	Political	Economic	Social
International				
Regional				
National				
Local				

Current responses can be mapped out in a similar way and then in the third stage new programme directions can be identified. The process can be used to generate principles relevant to a specific programme, but is best used as an input for strategy development.

[13] DFID (2002)
[14] Goodhand and Atkinson (2001)

Such 'conflict mapping' does not necessarily reveal how critical different factors are. We should be careful not to place excessive weight on service delivery as a factor in conflict. The case studies and literature review indicate that the critical issues for donors are equity and inclusiveness and these issues are certainly relevant to Service Delivery. Arguably, programmes will contribute to peace if they follow these principles and so they are sometimes used as proxy indicators for peace.

However, it is extremely difficult to quantify the importance of such issues in relation to conflict. There is an argument, pursued by Paul Collier formerly at the World Bank[15] (now CSAE Oxford) and supported by a considerable amount of data, that the driving force in conflict is not the 'grievances' of the excluded, but the 'greed' of those who use conflict as a means to achieve their own ends. This has led to a lively debate about the relationship between greed and grievance.[16] Collier emphasizes the importance of economic factors and self-interest in causing conflict and, in the view of other commentators, underestimates ideological and social factors. His findings have also been questioned on technical grounds. However, perhaps the most useful outcome of the debate has been the realisation that greed and grievance interact, and that it is unwise to think only of one or the other.

The DFID methodology avoids any kind of stereotype of conflict, but simply attempts to map out the factors on a case by case basis. At any rate, the prevalence of economic factors would not undermine the case for aid agencies to focus on equity and inclusiveness. These are, after all, objectives that aid agencies aspire to because they are integral aspects of development, explicitly stated in the MDG's. We may support the delivery of services such as education and health, but we must also ensure that the resources are not embezzled and that those who threaten schoolchildren and patients will be held accountable. This opens the way for closer relationships between the conventional service delivery sectors and interventions aimed at governance and security sector reform.

The DFID methodology can be used to map out specific aspects or issues relating to conflict. As an illustration, the following table maps out some of the factors relating to education that might need to be considered as a country emerges from conflict. This example refers to Mozambique.

Table 3: Factors relating to Education in Mozambique (emerging from conflict)

	Security	Political	Economic	Social
International	Peacekeepers not involved in protection	Donors focused on structures not policies	Debt repayments reduce budget	Limited international NGOs in education
National	Negative perceptions of the military	Policies based on exclusion	Weak policies for marginal areas	No legal control on discrimination
Local	Limited protection of children going to school	Limited representation of poor people	Curriculum not oriented to employment	History curriculum offends some groups

The table shows the need for a comprehensive or sector-wide approach that would include not only local and national aspects, but also issues relating to the functioning of the international community as a whole. An aid manager equipped with such an analysis could chart out a number of activities that could contribute to peace through education.

[15] Collier et al (2003). Also CPRU Section of World Bank website.
[16] Malone and Berdal (eds) (2000)

Nevertheless, the map is rather static and conflicts are liable to change and evolve. The DFID methodology examines the dynamics of conflict by looking at the interests, concerns and capacities of the key actors. This helps to identify threatening scenarios as well as positive opportunities.

In examining the case studies we will divide the responses into four notional 'phases' of conflict. This can be presented as a framework showing how responses have changed over time. The success of such responses could be measured by setting them against an analysis of the underlying causes and the dynamics of conflict. Unfortunately no record of such analysis exists from the time of the case studies. Therefore, we are unable to really evaluate the effectiveness of the responses. We can only record the actual pattern of responses and suggest indicators that might show the success of such responses provided that they were relevant to the specific situation. We will supplement this, where possible, by a subjective comparison of the underlying issues.

Table 4: Changes in the response and indicators in different 'phases' of conflict

Phases of violent conflict	Service delivery entry points	Assessing impact – Indicators
Ongoing conflict, pre-agreement	*Impartial provision of services* *Working on both sides* *Capacity building* *Engagement in social policy*	*Increased willingness of parties to facilitate access* *Cross border movement people* *Staff understand pro-poor perspective* *Parties seek advisory inputs*
Peace agreement/ settlement	*Service delivery used strategically to support peace* *Focus on marginalized areas* *Support to key decision-makers in service delivery* *Further advisory work on social policy* *Innovative work by INGOs integrated with government*	*Public support for peace in areas of programmes* *Reduced tension around equity and inclusion issues* *Planners able to influence politicians* *Donor asked for further support* *Coherent plan for service delivery in each sector*
Recovery	*Payment used as a lever for pro-poor change* *Focus on capacity building* *Users groups introduced in all areas* *Focus on areas of opposition*	*Staff remain in service delivery* *Development of pro-poor policy* *Improvement in services* *Representation of poor people in service delivery planning* *Staff recruited from areas of opposition*
Reconstruction	*Capacity building focused on social marginalized groups eg disabled people* *Strong focus on equity and inclusiveness*	*Staff available to match pace of rebuilding* *Physical reconstruction matched by pro-poor orientation* *Marginalized groups represented in users groups*

Note: Italics denote examples.

Section Two: Lessons from the Case Studies

2.0. Introduction

This Section will consider the impact of service delivery in different 'phases' of conflict. We will use four categories- ongoing conflict, peace settlement, reconstruction and post-reconstruction [This is not the standard "4 phases" of conflict commonly used in the literature.]

Measuring the impact of service delivery on development is considerably easier than measuring its impact on peace or 'avoidance of future conflict'. The records and reports do not clearly state whether a specific intervention was intended to address underlying conflict issues or were simply part of a general development response. Sweeping assumptions are commonly made about the relationship between development and conflict management. There are cases where an agency has claimed, in retrospect, to have made a major contribution to conflict reduction, but this was not explicit in its objectives and the logical connections are tenuous to say the least. Very few agencies have published material about the reasons for their choices and the balance between peace-building and developmental intentions. There are no records in our case studies of an organization making a strategic analysis that integrated its developmental objectives with an understanding of conflict.

For the purposes of this report, we will focus our attention on the four countries selected by DFID: Uganda, Mozambique, Cambodia and East Timor. The full case studies are attached in the Annexes. Although Cambodia, Mozambique and East Timor have now emerged from violent conflict, Uganda represents what is perhaps a more common scenario of a country that has emerged to a certain extent, but not completely. Despite renewed efforts to reach an official peace agreement in Uganda, areas of the country and, in particular, northern regions continue to experience significant levels of violent conflict.

Similarly, Ethiopia emerged from conflict in 1991 only to go back to war a decade later. Sudan has an ongoing peace agreement in the South but is experiencing serious conflict in the West. The countries of the African Great Lakes have all been characterized by continued eruptions of violence, followed by peace talks and more atrocities in a far from linear sequence. Indeed, Mozambique, Cambodia and East Timor could be viewed as the exceptional cases where strong international pressure has been applied to external forces and the peace has been, in effect, guaranteed by the international community with substantial aid inputs and even peacekeeping forces.

Mozambique is the most revealing of the studies and the most positive case from a developmental perspective. It was the huge turnout of people to vote in the elections after an initial peace agreement that really cemented the peace. People were able to demonstrate their commitment to peace by waiting to vote in orderly queues all over the country. We have already identified representation of poor people as a critical issue around the time of peace. Yet, what contributed to that event? Was good service delivery in remote areas a contributory factor? It seems impossible to tell.

Democracy may be an essential element in peace, but it does not appear without a thousand small local experiments in which ordinary people voice their concerns and learn how to work together to increase their influence. Service delivery may have a critical role in relation to long-term peace-building, but there is little evidence on which we can map out the connection. The Government of Mozambique made strenuous efforts to ensure that services reached the neglected areas and particularly those that had been bases for RENAMO. Nevertheless, ultimately it is only a guess that donors who participated in such programmes contributed to

peace. This problem of connecting inputs and outputs, outcomes and impact persists throughout our case studies.

2.1. Entry points for service delivery during ongoing violent conflict

One of the key issues that seems to emerge from the case studies is the importance of early engagement both to sustain people during conflict and also to strengthen capacity for a subsequent transition. This includes humanitarian support as well as development. In Mozambique it was found that households were able to rebuild their livelihoods more easily when they had been able to keep hold of their assets during conflict and/or were able to access social services and food aid.

Readiness for peace is not simply a matter of physical health, but also having the skills and orientation to cope with and take advantage of a new situation. Education is often given a high priority by people in conflict situations especially by those who have been displaced. They argue that education is often the only thing they can carry back home with them.

Provision of education services to displaced people and refugees while conflict still continues may be an important contribution towards sustainable peace. The benefit accrues not only to the students and families, but also in terms of retained staff capacity. Health staff trained in refugee camps on the Thai/Cambodia border proved a valuable asset in the reconstruction of Cambodia's health sector, particularly after the massacre of qualified health professionals during the Khmer Rouge regime. Health workers trained during emergency humanitarian assistance programmes in Mozambique similarly strengthened national capacity to restore services after the peace agreement. Yet, it is doubtful whether the donors who supported these programmes saw this as an objective at the time.

Can service delivery contribute to peace in a deliberate way? It is often claimed that extending health and education services into areas of opposition can lead to better communication and dialogue using services as a 'bridge for peace'. While initial emergency support in Mozambique focused on safe areas, strengthening the pre-war bias and attracting people from RENAMO-controlled areas, the trend changed as the possibility of peace became greater. Some NGOs began to engage in food distribution and health provision across the lines of conflict. They played an important role in opening up RENAMO areas, decreasing tensions and dismantling military control on movement. However, many other NGOs continued to work only on the government side, and could have contributed to resentments if RENAMO followers had known what was happening.

Probably such activities create the potential for quick recovery rather than peace itself. Such was the case in the reconstruction of the health service in Mozambique encouraged by foresighted policy work by a few well-informed donor agencies (see below).

Support to Mozambique's Ministry of Health

Supported by WHO and the World Bank, Mozambique attracted donor support by establishing a solid information base and realistic health policy even before the peace agreement. Acknowledging that major changes would have been required even without the war, the policy promoted equity and sustainability. While most donor agencies in Mozambique were reticent to support recurrent expenditure, the Swiss Development Cooperation provided budget support from 1990 onwards. This not only allowed the expansion of services, but also strengthened the information system, enabling the monitoring of reconstruction.

Pavignani and Colombo*, Providing Health Services in Countries Disrupted by Civil Wars: A Comparative Analysis of Mozambique and Angola 1975-2000,* WHO, 2001.

Accurate base line data is especially hard to come by in a conflict situation and so much analysis is based on best estimates from limited and out of date sources. Probably, the people in RENAMO areas thought they were doing well to get any service at all and did not realize that they were still lagging far behind other areas. Thus, the contribution of aid to peace could only be measured exactly if we knew much more about the flow of information.

In East Timor, the early engagement of the World Bank, even in prejudging the elections, was critical in opening the way for reformist policies. There is considerable evidence that a country emerging from conflict is likely to present opportunities for radical pro-poor change, but this may exist for a short window of opportunity. Pro-poor policies were introduced in East Timor, notably in the education sector, including the waiving of school fees and the wearing of proper school uniforms. They were the requirements that had tended to exclude poor people. Also, the school year was synchronized with agricultural cycles so that children could support their parents during critical times of the year without having to miss school. Despite young people having played an important role during East Timor's resistance, there was limited education reform in the secondary, tertiary and non-formal education sectors.

The case studies indicate that the most effective responses have been those that supported a credible state as in Mozambique and East Timor. It proved far more problematic to work in Cambodia after the peace agreement, because the legitimacy of the government remained in question. In Mozambique, the donors also gave substantial support through international NGOs, but the government, having developed social policies in the years before the peace, took effective steps to ensure that they worked in line with overall national policy. In Mozambique, the number of international NGOs rose from 7 in 1980 to 180 in 1990.[17] In Cambodia such NGO activity led to a bewildering array of different projects as there was no legitimate coherent national framework for channeling international assistance.

Policy interaction with government proved to be, at least in Mozambique's case, the most effective entry point. Early activity allowed the government to keep control of many other processes when the pace of change increased around the time of the peace agreement.[18] Because international NGOs, donors and UN agencies do not always choose their areas of operation based upon an analysis of conflict, but more likely an analysis of needs, they may contribute to peace or conflict almost at random.[19]

2.2. Entry points for service delivery during peace agreements/settlements

Peace agreements may provide significant opportunities to introduce pro-poor change. However, the case studies show a tendency to focus on quick and high profile results rather than delicate and difficult negotiation around sustainable development objectives, as demonstrated in the following table.

[17] Hanlon, 1991.

[18] A no of key actors were not willing to coordinate particularly UN agencies. They were reticent to coordinate with the Moh.

[19] This depends partly on the conflict situation. Assistance provided during ongoing conflict would need to be provided on the basis of need to justify it as impartial assistance.

Table 5: Competing goals for the health sector in East Timor [20]

Goals:	Competing Goals:
• Produce measurable results quickly • Disburse funds quickly • Ensure a coherent sector-wide approach • Provide services to all now • Develop health policies soon, before it is "too late"	• Achieve transition to full East Timorese management • Ensure national decision making and full ownership • Focus on building capacity • Ensure sustainability • Accommodate individual donor needs • Improve scope and quality of services • Consult widely on all policy issues • Stay flexible to avoid setting directions "too early"

In contrast with Mozambique, where health policy was developed prior to the official peace settlement, in Uganda the government's 10-point plan gave no room for social development and it was simply assumed that it would follow in the wake of economic recovery.[21] Instead, an attempt was made to use the health sector, without reform, to legitimize the peace. Nevertheless, the attempt to deliver services without reforming the system proved to be unsustainable.

Restoration or reformation of health services in Uganda in 1986

High expectations of health services led the government to focus on restoration of services that had existed in the past, but proved to be unsustainable such as physical rehabilitation and tertiary care. For a while, vertical programmes, such as the Expanded Programme of Immunisation (EPI), reflected positively on government and were used to demonstrate its reach into troubled areas. But when donor investment in primary health care was withdrawn, the result was informal charging and privatization.

Macrae (1997) and Witter (2004)

Cambodia's Peace Accords included a 'Declaration on Rehabilitation and Reconstruction', which called for restoration of the country's existing basic infrastructure and public utilities, including health and education.[22] However, the Declaration also limited the resources available for that process. It stated: "the main responsibility for deciding Cambodia's reconstruction needs and plans should rest with the Cambodian people", and "no attempt should be made to impose a development strategy on Cambodia from any outside source."[23]

While the United Nations Transitional Authority in Cambodia (UNTAC) nominally controlled the highly politicized public administration, its capacity was in practice very limited. Coupled with donors' unwillingness to recognize the legitimacy of the Supreme National Council (SNC), the latter led donors to override the emerging national structures. Direct donor negotiation with non-

[20] Tulloch et al, 2003.

[21] Macrae, 1996; World Bank, 2003; Waters, 2004.

[22] Declaration on the Rehabilitation and Reconstruction of Cambodia, point 10.

[23] Declaration on the Rehabilitation and Reconstruction of Cambodia, point 2.

communist factions also jeopardized the Peace Accords and UNTAC's mandate. The Khmer Rouge withdrew from the UNTAC/SNC framework in 1992. While donors were willing to support electoral processes, such support left unresolved the deeper problems of social inequality.

In East Timor, the Conselho National da Resistencia Timorese (CNRT) had drafted a development plan in anticipation of a likely vote for independence. While the scale of post-ballot confusion led to its abandonment, the plan did help shape subsequent thinking, especially on education.[24] Due to its engagement with the Timorese leadership before the ballot, the World Bank was able to respond quickly, launching a donor meeting and Joint Assessment Mission in which education and health were well covered.

The critical issue around the time of peace was the role of the state both in terms of legitimacy and also commitment to pro-poor change. Although this issue does not lose its importance in other phases, the opportunities at the time of peace are particularly crucial and may not reappear later.

2.3. Entry points for service delivery during initial reconstruction

While there are often important opportunities to introduce significant pro-poor policies in the aftermath of conflict, low absorptive capacity within nascent government ministries will be a serious constraint and may be coupled with donor reticence to engage directly with the structures of government whose legitimacy is in question. While donors are eager to focus on the direct consequences of war, especially reconstruction of the physical infrastructure, they tend to 'wait and see' when it comes to building or reforming national policy frameworks.

However, a number of commentators have praised the recovery of Mozambique's health sector. It has been described as,

> *…a visible success, spearheading and giving credibility to the whole peace process….. The expansion of health services prioritized neglected or previously inaccessible areas. People were exposed first to the state as service provider, receiving a tangible "peace dividend". Civil administration, policy, army, taxes, arrived in remote districts later than health services, schools or boreholes.*[25]

The initial reconstruction in Mozambique was rightly focused on rural areas and less privileged communities in an attempt to tackle pre-existing imbalances in service provision.[26] Health service use in rural areas increased three-fold between1994 to 1996. NGOs were allowed to revive health services in RENAMO-controlled areas. Retraining of health staff from RENAMO areas demonstrated government willingness to build peace. Further, as the only available professionals were from government areas, RENAMO authorities came progressively to accept health workers from outside, first employed by NGOs and eventually by the Ministry of Health, contributing to the progressive reintegration of rebel areas into a common administration.[27]

Because donors had few political inhibitions about the Mozambican government they successfully balanced inputs to the state and to non-state actors. In Cambodia, the World Bank stressed the importance of delivering public services through the state rather than by NGOs or international

[24] Nicolai, 2004.
[25] Pavignani and Colombo, 2001.
[26] Ibid.
[27] Pavignani, 2004.

agencies. It cautioned against the creation of parallel but similar programmes for different vulnerable target groups such as returnees and demobilized soldiers and other ex-combatants. However, donors were reluctant to accept the transitional authority and the dominance of Vietnamese backed State of Cambodia (SOC) government. The uncertain legitimacy of the transitional government, together with the limited capacity and unclear mandate of UNTAC, led to a very limited focus on physical reconstruction. Many donors bypassed the coordination mechanisms of both UNTAC and the transitional government and directly supported NGOs at the local level. Total funds budgeted for NGOs working in health in 1991 were US$16.6 million and rose to US$28.8 million in 1992.[28] Donor support was focused disproportionately around the capital and in the northwest. The United States and European donors specifically sought to direct aid to the non-communist factions based on political criteria rather than basic needs.[29]

The Coordinating Committee for Health (CoCom), supported by WHO, provided a non-political forum for the factions to meet. This facilitated their integration into a united health administration. However, UNTAC, international agencies and NGOs remained reluctant to engage with CoCom or follow its policies and guidelines, in part, due to its association with the questionable transitional government.[30]

Reintegration of health workers from different faction within Cambodia's public health system

WHO supported the Coordinating Committee for Health, providing a less politicised space for factions to meet and discuss the incorporation of health workers, trained in different systems and working with different political factions, into the national public health system. Promoting inclusion of health workers was particularly important given the depletion of qualified individuals during the Khmer Rouge regime. In November 1993, ahead of a newly mandated government, WHO, along with the interim health administration and with senior personnel from the four political factions supported the reintegration of health workers of three of the four factions into the interim health administration.

Hun Chun, 1993 cited in Lanjouw, 1999

While there was significant donor commitment to support peace-building in Mozambique, individual donor priorities still prevented an effectively coordinated response. This put pressure on government structures and led to distortions in the spread of health services. Many of the rehabilitation projects lacked exit strategies that would ensure sustainability.[31]

Moreover, the UN agencies and the EU did not accept UN coordination and/or kept a distance from service delivery ministries. Nevertheless, the response in Mozambique was probably the most coherent of all the case studies.

In East Timor, ECHO promoted international NGO collaboration with the Interim Health Authority (IHA). ECHO agreed standard levels for certain health expenditure, including for staff, rehabilitation and drugs. The government's health sector rehabilitation and development programme clarified the role of international NGOs in providing emergency services while the Interim Health Authority focused on building longer-term national policy. However, the complexity of donor aid inhibited national ownership and prevented the integration of all funding sources into

[28] Lanjouw, 1999.
[29] Ibid.
[30] Macrae, 1995.
[31] Montes, 2000; EC Evaluation of Actions Financed under Article 255, VII EDF, 1997.

the national budget, while lengthy procurement procedures delayed implementation.[32] East Timor's Trust Fund was set up to increase coordination, but needed energetic efforts to achieve its objective.[33] On a more positive note, a deliberate attempt to bridge the gap between relief and rehabilitation was made by the East Timorese Health Professional Working Group. Formed within days of the conflict, its comprehensive needs assessment spanning humanitarian assistance and reconstruction was favorably received by donors. Yet, the critical issue remained the performance of government. The 'Community Drive Reconstruction Programme' rightly prioritised reconstruction outside Dili, and demonstrated the priority the leadership placed on reaching the population most in need. Nevertheless, these initiatives ran into difficulties later due to the absence of agreed policies on wages and the role of local government. It is not enough to have the political will; there must also be attention to detail in the implementation.

Our case studies confirm the critical role of the state especially in the period surrounding peace when it is vital to restore confidence in the governing authorities. In this period, budgetary support for salaries and training of staff in the health and education sectors may be appropriate in spite of the risks associated with weak financial oversight and the issue of the international community legitimizing a government through engagement with public sector ministries. This would seem to be a clear case in which a particular response is only appropriate for a limited period and at the right 'time'. However, in Mozambique, such support was actually provided even before the peace agreement and it has been argued that if such support had not been given health staff would have sought private incomes or introduced illegal charges as in Uganda. In such cases, interests would develop around this illegal practice and it would be difficult to correct later. The long-term impact of such developments would be to marginalize poor people. What is clear is the need for extended budgetary support in situations where this is appropriate and/or exploring channeling of funds for service delivery staff through non-state/INGO actors.[34]

Table 6: Case Study -Health Rehabilitation in Uganda[35]

	Positive Developments	**Negative Developments**
Anticipated	Physical rehabilitation of infrastructure. Improved immunization coverage. Improved supply of essential drugs.	Dominance of vertical programmes. Limited capacity building.
Unanticipated	Physical rehabilitation as basis for community participation and reconciliation.	Projects rather than policy. Limited institutional development. Unsustainable rise in recurrent costs. High levels of aid dependency. Poor coordination and inequitable distribution of aid resources. Skews service provision to urban areas.

If poor people are marginalized by increasing costs, the likelihood of community participation in development will be reduced. Such local participation is in any case difficult to achieve. State designed efforts to promote decentralization and strengthen provincial and local authorities in Cambodia were less successful than later UNDP support for local management of rural development. It seems that people were wary of any link with the central authorities. At the same time, the rapid reintroduction of a market economy resulted in villagers being less willing to collaborate without pay for public works.[36] Many of these factors seem to reflect attitudes towards

[32] Rohland, 2002.
[33] Ibid.
[34] Pavignani, 2004.
[35] Macrae, Zwi and Gilson, 1996.
[36] Ovesen, 1996, cited in Bray, 19999 and Kao Kim Hourn, 1998.

government and emphasize the importance of attention to attitudes as well as actions. In East Timor, where the people were enthusiastic about the peace, the level of popular/public participation has been considered low. While the World Bank's Community Empowerment Project strengthened community capacity to participate in local governance discussions, it did not address longer-term issues of local governance. A number of the development councils established under the project are thought to have been dominated by elites.[37] There were efforts to re-establish the pre-existing Parent Teacher Associations, but it proved difficult to engage non-health stakeholders in counterpart local health organizations.

2.4. Entry points for service delivery following reconstruction

The continuation of reconstruction aid after the initial post-conflict period is a critical issue. In many cases, donors have been criticised for withdrawing too quickly thereby contributing to the creation of unsustainable national structures. [38] However, in some favoured countries, long-term support has created a risk of dependency or allowed governments to avoid difficult, but necessary policy decisions. For example, in Uganda, aid accounted for 62% of health resources in 1990-91 and by 1998 this figure remained unchanged.[39] Ongoing conflict with the Lord's Resistance Army (LRA) in districts of Northern Uganda has hampered efforts to provide social services. With large areas of the south and west of the country having seen significant improvements, failure to redress this imbalance has exacerbated historical inequities and fuelled continuing resentment.

Continued high levels of aid dependence may result in greater accountability to be given to donors as opposed to national demands. In 1999, Mozambique's National Health Service relied on external aid for 50 percent of its recurrent and 90 percent of its capital expenditures.[40] This dependence may have weakened Mozambique's ability to negotiate its national policies with the IMF and World Bank.[41]

Efforts to reduce high levels of aid dependency and inappropriate patterns of provision have often centered on initiatives such as user fees and performance-based partnership agreements. There remain differences of opinion regarding the most efficient system. In Cambodia, models of both contracting-in and -out have resulted in improved pro-poor service delivery.

Contracting health services in Cambodia

Cambodia has implemented performance-based partnership agreements carrying out pilot projects for contracting-in and -out of health provision. While both contract models indicate significant increase in service use and decrease in family expenditure, there are contradictions as to which is the most effective.

A contracting-in pilot, instituted by HealthNet International in Pereang district, one of the poorest in Cambodia, reported in 1999 "a decrease in total family health expenditure of some 40% from $18 to $11 per capita per year." Local ownership was promoted through decentralized sub-contracting.

While fee exemptions in Pereang were found to reach the well-connected rather than the poor, in Sotnikum District, Medecins sans Frontieres and UNICEF introduced Health Equity Funds. The Fund appeared to improve effectively access to hospital care for the poor, but did not cover expenses of caring for patient's dependents.

Based on Soeters, 2003 and Van de Put, 2002

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[37] Rohland, 2002.
[38] Macrae (1999)
[39] Save the Children, cited in Macrae 2001.
[40] Brown, 2000.
[41] Hanlon (2002)

consultation with local civil society through, for example, making enhanced debt relief conditional upon the government's adoption of a poverty reduction strategy paper (PRSP). However, without any reliable funding base from within the country through state channels, local civil society has remained dependent on outside support.

2.5. Conclusions

Working within the Ministry of Health, Enrico Pavignani was closely involved throughout the Mozambican peace process. He concludes,

Transitional processes are marked by uncertainty and change, submerged in background noise and shaped by contradictory data and goals. Only by understanding what is under way you can steer in the desired direction. Thus, the strength of the Mozambican health recovery strategy was in the solid roots of the analysis behind it.[42]

Unfortunately, there is a tendency to dispense with the analysis at the time of peace only to assume that conflict is no longer an issue and rely on preconceptions about rehabilitation and reconstruction. The DFID methodology characterizes donor positions in three broad styles of working:[43]

(1) Around conflict: avoiding conflict areas and issues as far as possible;
(2) In conflict: adapting as far as necessary in order to continue normal programmes; and
(3) On conflict: using aid strategy and policy to influence the impact of conflict towards development objectives

As a country approaches peace, the focus of attention should shift from addressing the basic needs of the affected populations during conflict through emergency humanitarian work and restricted forms of development to addressing the underlying causes of conflict in order to move society towards sustainable peace. As such, the strategic posture of donor agencies should move from working 'around' conflict, or working as best they can 'in' conflict, to working 'on' the root causes.

Donors who understand the long-term dynamic of conflict will seize the opportunity of peace to engage more vigorously to address the underlying causes. It is worth emphasizing that humanitarian assistance can play an important role in freeing up poor people from tasks relating to survival and giving them a greater opportunity to participate in wider processes. Artificial distinctions between relief and development do not fit with approaches that seek to build sustainable pro-poor peace. Similarly, aid managers should not seek to impose preconceptions about the transition form conflict to post-conflict, but rather maintain a steady focus on the underlying causes and try to move ahead of the events. If they do not work hard to preserve capacities during conflict, they will face a much greater task after the peace. By implication, development and humanitarian actors need to work closely together to provide assistance to sustain poor people with a strategic purpose of supporting the peace.

In Uganda, Oxfam GB blamed donors for making an artificial distinction between relief and development funding criteria that made it impossible to provide long-term support to a settlement project for people displaced from Sudan. Thus,

[42] Pavignani, E (2004) personal communication
[43] Reflecting DFID (2002)

> *It was simply not possible to confine actions to such tight definitions. 'Relief' and 'development' might appear to be fundamentally different… but the differences are essentially theoretical.*[44]

Funding continued while the purpose was relief, but stopped as soon as the development label was applied. Save the Children had a similar experience when a proposal to strengthen district health authorities in Burundi was rejected as 'too sustainable' in a situation regarded as humanitarian.

Settlement in Uganda

The Ikafe and Imvepi settlements were established in northern Uganda in 1995 and consisted of nearly 50,000 people displaced from southern Sudan. Most of them were from minority tribes and 40% of the households were female-headed.

International NGOs, including Oxfam GB, became heavily involved and tried to develop the settlements into living communities. Donors did not guarantee long-term support and so the settlement was in a constant state of crisis. This contributed to serious problems of staff morale and retention.

Summarised from Payne (1998)

The case studies indicate not only that the role of the state is crucial, but that perceptions are also very important. Although the participation of the people is vital for sustainable development, at the time of a peace agreement government must put its stamp on the situation through appropriate policies. The success of the Mozambican health recovery process was based on a clear top-down strategy that persuaded people that the government was acting fairly and in the interests of poor people. Participation was not a pre-requisite of the process but followed from it. As reported,

> *We wrapped into technical cloths what was essentially a political decision. It was not the best line of action but it honoured at least the main concerns which were equity and efficiency. Everything else was neglected.*[45]

Conventional views of peace often lack a pro-poor orientation, but, instead, focus on general rebuilding of the nation. The Mozambican experience indicates the need for a government to take a stand on its values and take the lead before other actors step forwards. As stressed, *"[i]f we had waited until other concerns were taken into account, donors and NGOs would have moved ahead as they always do, and done a lot more damage."*[46]

Artificial divides between phases of conflict and especially related to post-conflict development undermine efforts to support a pro-poor transition. There is a considerable danger that too rigid a view of 'phases' will lead to inappropriate funding choices. Changes in the nature of these responses over time need to reflect the nature of the conflict itself and the specific country rather than a general set of rules about different 'phases'. The SCA Framework introduced in section one describes the history of responses to a particular conflict, but does not necessarily indicate that the same stages should be followed elsewhere. Changes in the response in Mozambique may be presented as follows:

[44] Payne (1998) pviii
[45] Pavignani E (2004) personal communication
[46] Ibid.

Table 7: Changing Health Sector Service Delivery Response to Conflict in Mozambique 1980-1991.

Phases of Conflict:	Service Delivery Entry Points:	Assessing Impact – Indicators:
Ongoing conflict, pre-agreement	*Impartial provision of services within areas under control of both parties to the conflict.* *Working on both sides.* *Capacity-building training provided to health workers in IDP camps.* *Engagement in social policy.* *Provision of budgetary support.*	*Increased willingness of parties (RENAMO) to facilitate access.* *Cross border movement.* *Staffs understand pro-poor perspective.* *Parties seek advisory inputs.* *Donor willingness to support MOH policy.*
Peace agreement/ settlement	*Service delivery Health used strategically to support peace.* *Focus on marginalized areas.* *Support to key planners in service delivery.* *Further advisory work on social policy.* *Innovative work by INGOs integrated with government.*	*Public support for peace in areas of programmes.* *Health and service delivery prioritised above other areas of government local authority.* *Reduced tension around equity and inclusion issues.* *Planners able to influence politicians.* *Donor asked for further support.* *Coherent plan for service delivery in each sector.*
Recovery	*Payment of staff salaries in key locations/sectors.* *Payment used as a lever for pro-poor change.* *Focus on capacity building.* *Users groups introduced in all areas.* *Focus on areas of opposition.*	*Staffs remain in service delivery.* *Development of pro-poor policy.* *Improvement in services.* *Representation of poor people in service delivery planning.* *Staff recruited from areas of opposition.*
Reconstruction	*Capacity building focused on social marginalized groups, e.g., disabled people* *Strong focus on equity and inclusiveness.*	*Staff available to match pace of rebuilding.* *Physical reconstruction matched by pro-poor change.* *Marginalized groups represented in users groups.*

Note: Italics denote examples

Although the inputs may vary over time, the reasons for this are to do with the underlying nature of the conflict. For example, using the SCA matrix, the conflict in Mozambique during the 1980s could be mapped, rather simplistically, as follows:

Table 8: Causes and Factors Relating to Conflict in Mozambique

	Security	Political	Economic	Social
International	*South African arms to rebels*	*Pressure on Mozambique's leftist policies*	*Aid focused on Maputo*	*International NGOs pursue own strategies*
National	*Indiscipline of armed forces*	*Bureaucratic inertia-power centred in Maputo*	*Neglect of peripheral areas*	*No legal control on discrimination*
Local	*Violence causing breakdown of trade*	*Limited representation of poor people (on both sides)*	*Lack of development outside Maputo*	*Tension with traditional leaders*

To be really useful, such a matrix would need to include far more details, but, even in its simplest form, it indicates the need for policies that recognise the exclusion of remote areas and to reform the bureaucracy. It also indicates that this might change as other factors, such as external involvement, changed over the course of time. Those donors in Mozambique who made such a strategic analysis recognised that the issue was not simply to protect or rebuild the infrastructure, but to create a better balance between the government and the people. It was important to be especially sensitive to the alienation of traditional leaders and others who had benefited under the Portuguese regime, but had been deliberately marginalized by FRELIMO. Of course, the most vital step of all was to restrain South Africa from its policy of destabilization.

Strategists with a wide view of the underlying causes were able to adjust as the situation gradually evolved. However, they did so in relation to the specifics of the Mozambique case rather than from an abstract perception about the appropriateness of responses at different 'phases' of conflict. The underlying approach remained the same but the intensity of the response varied in different 'phases'. While important opportunities for peace-building may exist in all phases, the case studies highlight the lasting impact of early engagement to both sustain poor people during conflict and strengthen capacity for subsequent transition and reconstruction. Moreover, by engaging early, donors were able to come to a closer understanding of the underlying issues as well as the capacities of those they worked with. When peace came, their decisions were informed by a deep and specific understanding of what was and what was not possible and so they moved forwards quickly.

The focus of activity after the peace has generally been on physical 'reconstruction' rather than social transformation. This reflects a shallow understanding of the way in which violent conflict permeates society. If generalizations must be made, the focus should be on changing relationships so that the interests of the poor are better addressed, although it is conceivable that, in some cases, it might be better to focus on 'national unity' or even supporting the government as an end in itself

What our review of 'phases' in the case study countries does confirm, and very strongly, is that the window of opportunity for pro-poor change is open only very briefly. Therefore, all interested parties must be prepared for it in advance. Policies and approaches should not change direction suddenly, but will need to vary in their intensity, as will the balance between relations with the state and non-state actors. The critical period is just before a peace agreement and immediately afterwards. In Mozambique and East Timor, major policy changes were charted out with the future government before the end of the war and implemented rapidly once peace was declared.

By contrast, such changes were not made in Cambodia and tensions have remained. The scale of violence of the past has not been repeated, but the country has remained politically unstable. In the absence of strong pro-poor pressure, there has been a tendency towards greater disparities at all levels. This could have been predicted in advance by making a comprehensive and strategic assessment. Then, the tactics and policies could have been made to reinforce the long-term and sustainable objectives – provided that political factors could be managed in the interests of development.

SECTION THREE: Towards Good Practice – Implications of the Study

3.0. Introduction

The principal characteristic of a country emerging from conflict is that it is open to further change. The case studies indicate that there are likely to be pressures from those people worst affected by the violence towards creating a more equitable society and in support of pro-poor change. However, there are other forces that work against the interests of the poor and these may be more powerful. Political and criminal elite groups often find themselves in an advantageous position at the end of conflict with few constraints on their behaviour. Constitutional and legal checks may be practically non-existent. They may have assets, while others have been reduced to subsistence. As well, they may have the advantage of political influence and connections.

In Mozambique, with external help, a strong pro-poor movement that had continued through the war was able to assert itself. Yet, in the other case study countries the key problem of the peace has been a sense of growing disparity. This is often measured, at least by poor people, in terms of access to health, education and other services. With their assets severely reduced by war, the poor are unable to pick up on new entrepreneurial opportunities. Aid focused on the economic sector often passes them by. The process is further compounded if health and education services are privatized and user fees introduced. The working poor might be able to afford these services one day, but they face a crisis in the immediate aftermath of conflict.

In this Section, we will map out the implications of the case studies in relation to the policy issues that may arise for aid managers in the service delivery sectors. We begin with the issues relating to working with government, then look at more direct links with the people and finally examine the way in which donors work collectively and end with some common obstacles.

3.1. Working with National Government

Legitimacy and Prioritisation. World Bank research indicates that improvements in social policy have the highest impact compared with other development interventions in post-conflict situations.[47] Firstly, changes in social policy can greatly improve the efficiency of development inputs. Secondly, such inputs may help to consolidate and preserve the peace. After a conflict, people expect government to deliver benefits in terms of services such as schools and health posts. Confidence in the new government will depend, in the eyes of many, on this ability. Related World Bank research indicates that a, "…combination of policy improvement and aid reduce conflict risk by around 28% over five years".[48]

Surprisingly, and with the exception of Mozambique and East Timor, we have found that social policy is an area in which donors have generally been reluctant to engage. In the aftermath of conflict, the focus is usually on the direct consequences of war especially reconstruction of the physical infrastructure. The reason may be partly that physical reconstruction has a higher profile and partly that work on social policy is much more difficult. Low absorptive capacity within nascent government ministries makes donors wary to invest in pilot initiatives. They fear that staff may be transferred before policies have been enacted and so they tend to feel that substantial engagement should wait a year or two. The common practice is to focus on reconstruction first and leave the issue of pro-poor change for later. Our evidence raises serious questions about such an approach.

[47] World Bank (2003c) p4
[48] Ibid.

For DFID, the critical issues around which all others revolve is likely to be the orientation and capacity of the government that emerges at the end of a conflict. The case studies show that donor responses in such situations are likely to be influenced by political factors. Peace agreements are often sufficiently important to attract widespread media and political attention. The level of public interest and extraneous political interests may influence levels of spending. The alignment of the government may also affect levels of confidence and investment. The climate for donors is not always one in which a rational analysis of pro-poor opportunity takes the highest precedence. Many of our sources have lamented that the levels of aid and timetables for spending reflect a wide range of political considerations rather than a realistic appraisal of actual need. The imposition of structural adjustment policies as a condition of aid has also been vigorously questioned, as for example by Hanlon in the case of Mozambique.

The critical issue is timescales. Extraneous pressures often result in short-term and preconceived approaches. The problem with many of the aid inputs for recovery is, as Macrae emphasizes throughout her study,[49] that they are unsustainable. This is not simply a matter of capacity, but also of political will. For development actors, the critical issue is the commitment of the state to pro-poor change. In many cases, the state may give such commitments, but the reality may be different. Here again, conflict analysis offers a way forward by examining the interests and concerns of various actors.

The planning of service delivery in advance of the peace agreement in Mozambique, as already noted in section two, made social services the leading edge of government action to consolidate the peace. By contrast, Uganda prioritized economic development and seems to have been considerably less successful.

In general, the proportion of aid budgets allocated to health and education is relatively modest, an average of about 10% of the total in the following sample:

Table 9: Allocations of Aid in Selected Post-conflict Countries[50]

% of Total Aid Budget	Education	Health	Total
Cambodia 1992-7	8	6	14
Mozambique 1993-4	1	6	7
Bosnia 1996-7	4	5	9
Afghanistan 1997-9	2	10	12

The first major point in relation to government is to focus on addressing pro-poor change through early engagement especially in social policy. A second is that our case studies indicate the importance of an integrated approach. This refers not only to integration within sectors, or Sector-Wide Approaches (SWAPs), but also integration across sectors. Roads, judicial systems and support for police are essential if people are to return to school and attend health systems. Girls, in particular, will not go to school if they are likely to be attacked. People will not participate in politics if they are devastated by ill-health. They will not attend meetings if they have nothing to eat. A study in Mozambique revealed the following:

> *…although the supply of education is increasing as schools are rebuilt, household demand for education continues to be deficient. This is partly because children are needed to help rebuild household livelihoods.*[51]

[49] Macrae (2001)

[50] Derived from Forman and Patrick (2000) pp 80,185 and 325. Also Atmar and Goodhand (2002) p34

[51] De Souza (2003) p70

It must be recognised that pro-poor policies will have to be argued for and negotiated against other interests. In brief, a new government will be faced with issues of debts and pay-offs. The support of some elements may only be secured by using the resources of the state. This could easily manifest itself as inequitable or non-transparent behaviour. Government priorities may be distorted to reflect its internal politics and what is presented to donors as the interests of the people may actually be little more than an attempt to buy political support.

Much of the literature on Mozambique, for example, praises donors who put the government's priorities above their own. However, this would not always be the best strategy. Donor support to Uganda may have made it easier for the government to overlook the real causes of conflict and justifiable grievances of the north. For donors to simply move into 'solidarity' mode with a new government might not be in the best interests of poor people. Here again, specialized analysis is needed. It is important to recognise that poor people may be badly under-represented. They are busy trying to recover their own lives and unable to engage in wider processes of change. They need help and encouragement from donors to participate.

In all our case studies, the countries emerging from conflict received sudden and substantial inputs from the international community. Yet, the capacity and financial systems are at their weakest in a country emerging from conflict. Pressure on aid managers to spend may be highest just when the political and administrative structures are weakest. This opens the way for corruption and patronage on a massive scale. A contractor who survives through a period of conflict and is capable of building dozens of schools will wield enormous influence over politicians who are struggling to rebuild their own livelihoods and status. The unintended consequence of reconstruction aid may be, as in Kosovo, at least to an extent, to corrupt political forces that may already be struggling with unfamiliar concepts and pressures.

Donors tend to be too optimistic. There are very few cases of donors focusing on corruption. Yet, this will be a central problem and one that will spiral out of control if donors are lax in their oversight. Donors tend to equate peace with support to a new government too easily. This is in itself a political act, i.e., taking sides in a situation that may still be teetering on the edge of conflict. Observers have questioned this tendency of donors to legitimize the post-conflict government and regard all other opinions as subversive,

'*Who defines peace, who is part of the dialogue and whose voices are listened to or ignored?*'[52]

The reasons for donors taking sides in a conflict are often good ones. They argue that the best way to support the peace is to encourage investment and therefore it is best to play down the problems and emphasize the successes. However, the end of hostilities is not necessarily the moment at which all the underlying problems also disappear. Investment may re-open disparities that were causes of conflict.

Aid managers should be wary of the general euphoria that follows peace. It may overlie interests and tendencies that are contrary to development objectives. Officials in line ministries may be under pressure to follow similar optimistic assumptions. They may distort figures in order to suit their political masters. Without unusual zeal on the part of the top political leadership, the outcome may be detrimental to poor people. It is a chilling reflection of these problems that the World Bank has found:"*There is a 44% chance of resumption of conflict in the first five years after a civil war".*[53]

[52] Atmar and Goodhand (2002), p65.

[53] Collier et al (2003) p83

Capacity Building. The issue of capacity building comes up constantly in our case studies and deserves further analysis and illustration. Aid managers in countries emerging from conflict are often faced with a paradox. They want to help quickly and on a substantial scale, but such help may have negative impacts. The country is open to change, but the capacity to bring about change is lacking. World Bank research indicates that absorptive capacity for aid is no higher than normal in the first three years after the conflict and yet aid inputs sometimes reach astronomic proportions in that period. Absorption capacity doubles its normal level in the following seven years, but aid inputs have generally declined by then.

It is tempting to sideline the issue of policy change and focus on reconstruction. However, a massive programme of medical clinic reconstruction, for example, will divert what little management capacity there is in the health sector away from reform and tend to perpetuate the status quo. If change does not take place at an early stage, vested interests may re-assert themselves. Experience in the four case study countries suggests that the window for radical policy change is open only for a relatively short period.

A key text relating to the health sector, and based on a similar set of case studies, is Joanna Macrae's *Aiding Recovery*[54]. She argues that an excessive focus on supply of drugs and equipment, and rapid reconstruction of health facilities often outstrips the capacity of the systems and human resources that should support them. Such inputs may prejudice the development of health policies by the national government. Key staff are kept too busy dealing with drugs arriving at airports and have no time to work on policy and administration, including such vital areas as human resources and finance.

Drawing on studies of Cambodia, Uganda and Ethiopia she concludes that agencies have not given sufficient attention to long-term sustainability. Governments may be left with responsibilities they cannot meet, potentially undermining public confidence at a time when this can be most dangerous. Elites may be ready to step in with solutions based on private profit, but these will only benefit the few. Capacities do not suddenly increase after a peace agreement.

Health Planners in Uganda

Many health staff, particularly those at senior level, left Uganda during the conflict, while those who remained received low and irregular payment. *'Being isolated (by conflict) during the 1970s and the early 1980s, Uganda was denied opportunities to participate in international health debates particularly those relating to primary health care. The combination of these effects of conflict on policy and management meant that when relative peace returned to most parts of the country in 1986, national capacity for policy development to guide the rehabilitation process was extremely limited.'*

Macrae (1997) p185

The depletion of technical capacity during conflict is not quickly redressed. It is often assumed that teachers are ready to teach and health workers to deliver health. Unfortunately this is not usually the case. Many staff will have been involved in the conflict and others may have been driven out of the country. Some will have been killed. Others will be preoccupied with rebuilding their own homes and lives. Yet more will be afraid to work because of security reasons, fear of

[54] Macrae (2001)

retribution or non-payment of or extremely low salaries. Incentive and training support can have an important role in reengaging staff capacity and morale, particularly important given the high social regard often accorded health staff and teachers.

Despite the risks associated with weak financial systems and concerns about legitimising a government that has yet to prove its credentials, our case studies suggest that budget support may be appropriate especially in countries just emerging from conflict. This is not so much because donors should 'give peace a chance', but because such subsidies offer an entry point for further engagement such as in building capacity to develop, implement and monitor social policy.

Staffing in Uganda:

> The Continuing conflict in northern Uganda, coupled with low incentives, has resulted in difficulties in recruiting and maintaining health workers. In poor areas, such as the Soroti District, once donors withdrew their support for the recurrent costs of primary health care, particularly staff incentives and basic drugs, utilization of public services diminished while privatisation further increased.
>
> Macrae (2001)

However, donors should be careful not to give with one hand and take away with the other. It is common to find that around the time of the peace agreement aid agencies are desperate to increase their own staff capacity and may, inadvertently perhaps, poach staff from the service delivery ministries they are trying to help. In Mozambique, funds channelled through government were used to set up separate project management units and salary 'top-ups' for public sector staff engaged to work on donor programmes. International NGOs also took a large number of staff away from core line ministry functions.

Donors should also be careful that their staffing does not perpetuate inequalities and elitist tendencies that are in contradiction of pro-poor change. A conflict review of programmes in Nepal at the time of the (abortive) 2002 peace talks suggested that DFID should introduce affirmative action to counteract the advantages of elites in recruitment. It was proposed that job requirements should be strictly practical, requirements for academic qualifications kept to a minimum and minority language skills given higher priority.

Decentralisation is often advocated as a general principle in countries emerging from conflict.[55] It may help to reduce centrifugal pressures that may have arisen during conflict. Nevertheless, there is a risk that it may simply weaken central government. Accordingly, it seems better to think in terms of the involvement of peripheries in an inclusive process.

In East Timor, decentralization was necessary simply because of communication problems, but does not seem to have made much difference to the pro-poor focus of education services.[56] In terms of pro-poor service delivery, there may be little to choose between central and local government. The key issue is involvement of people who have a stake in the services.

3.2. Non-state actors.

Working through NGOs. Donors often turn to non-state actors as countries emerge from conflict precisely because government capacity is weak or untrustworthy. This, of course, has its dangers.

[55] Saferworld/International Alert (2000)

[56] UNDP, 2002, cited in Nicolai, 2004.

The case studies include a number of highly innovative programmes launched by international NGOs. These may receive wide acclaim, but, unless they are rooted in longer-term and sustainable processes, the benefits are usually lost within a short time. Sometimes they are described as demonstrations or experiments. However, without a clear strategy to link them to permanent pro-poor change, they will be ineffective.

There are strong arguments for supporting the State. It has been weakened by conflict and probably represents the best long-term protection for poor people. In a wide-ranging study of recovery processes, Macrae warns against bypassing the State as follows:

> *Because many rehabilitation interventions are implemented outside state structures, the rehabilitation process often does not serve to strengthen these institutions in the longer term.*[57]

Nevertheless, peace will be best sustained by representative processes in which the poor can assert their interests. Some intrinsic value may be placed on the role of non-state actors in representing the poor and helping them to participate. This is quite different from taking over the delivery of services. In a number of countries, civil society organisations have played a crucial role in representing poor people through such mechanisms as the PRSP. The Millennium Development Goals (MDG) concerning the empowerment of women is particularly relevant in a situation where women are otherwise likely to be marginalized.

The issue is not so much a choice between state and non-state actors, but which channel is most effective in reflecting the interests of poor people, both short and long-term. The ultimate goal in relation to sustainable peace is likely to be strengthened representation of poor people. Service delivery may need to be a means to that end rather than simply a route towards physical improvements. Strategic choices have to be made based on a wider analysis.

Privatisation. Confronted with the problems of less dynamic situations, aid managers have considered contracting out health and education services, despite the risk that the benefits will accrue to elites and foreign interests and could exacerbate tensions. The results from such experiments provide no clear or simple lessons.[58] Much seems to depend on local circumstance. Yet, aid managers seem keen to replicate contract systems.

Privatization can only be moderated to a limited extent through local involvement, especially if funding is top-down. Introducing privatization to compensate for a weak state is a dangerous course because it will further undermine the state and may lead to increased inequality. Studies have shown that it is important to focus on regulatory measures before encouraging privatization.[59] Addison's general study of recovery in Africa concludes:

> *Donors have been extraordinarily naïve in their approach to privatization. In particular they have neglected the issue of post-privatization regulation, despite the evidence from their own countries that regulation is crucial to maximizing social gains…*[60]

In practice, service delivery generally involves an interaction of government, non-state actors and people. The important point is to balance the different ingredients according to the needs of a particular situation. The risk of capture by elites and the relative weakness of poor people after

[57] Macrae (1997)
[58] Not all experiences are as positive as the study of Cambodia by Bhushan, Keller and Schwartz (2002)
[59] Castel-Branco et al (2003)
[60] Addison in Addison (ed) (2003) p272

conflict suggest that vigorous measures are needed to encourage pro-poor change. Thus, in the case of privatization, a regulatory framework coupled with users' groups would provide the necessary restraints.

Privatization in Mozambique

Businessmen, high ranking army officers and state officials pressed for privatization; it offered an investment opportunity for capital accumulated during the war through corruption and the extraction of a 'war tax'. Modernizing the army entailed demobilizing many veterans, and selling public assets to them at subsidized prices eased their transition into the private sector and avoided political trouble. Many senior officers, generals, and state officials were to benefit from privatization over the next decade.

Castel-Branco et al (2003) p157

3.3. Pro-Poor Change

Peace is essentially an opportunity for different sections of society that have been pulling apart to work more closely together in partnerships. This is not only a way to avoid further conflict; it is also the key to development. Neither public nor private provision of services will be effective without the participation and involvement of the local community. Of particular concern to development actors is the representation and involvement of poor people.

Countries emerging from conflict may be particularly suited to the introduction and support of Parents Associations in schools and Users Groups in health services. By involving the community it may be possible to secure additional support for schools and health centres. However, it is the participation that is important rather than, as often happens, the financial relationship. Too often aid programmes offer incentives to local participation that actually undermine it. People become unwilling to interact with the state unless they are paid to do so.

The critical issue is to leave the initiative or 'ownership' in the hands of the people rather than simply use their participation for our own purposes. In Uganda, monitoring of the education sector became part of government's own information campaign and resulted in a decrease in 'leakages'.

Promoting Accountability in Uganda

In 1996 a public expenditure tracking survey of local governments and primary schools revealed that only 13 percent of the per-student capitation grants made it to the schools in 1991-95. Most funds went to purposes unrelated to education or for private gain and the survey resulted in indictments of district education officers. To enable schools and parents to monitor local expenditure, central government began a mass information campaign, publishing data on monthly transfers of grants to districts in newspapers and to broadcast them on the radio. It required primary schools and district administrations to post notices on all inflows of funds. From 1995-2001 all schools experienced a large drop in leakage, and most particularly amongst those schools with access to newspapers.

World Development Report 2004, Making services Work for Poor People, The World Bank, 2003

Mechanisms such as the World Bank's Social Investment Funds have been successful in supporting Parents' Associations and Users Groups, but it is important to be clear whether the objective is to rebuild the school or to form a strong parents' group. If the amounts of money are large, then the project may lead to short-lived top-down organisation dominated by local elites. It

is much more difficult to create participatory local bodies in which the voices of poor people and women are heard.

In the chaos of a post-conflict situation it is common for teachers and health workers to absent themselves or for posts to be left vacant. It is only through pressure from the community that such faults can be corrected. The primary role of poor people is to put pressure on higher authorities to make the services work effectively.

However, the ability to involve local people may depend on their level of confidence in government. In East Timor, where the people were considered enthusiastic about peace, the level of participation was quite low. They applauded the peace, but lacked confidence in the authorities. A long period of alienation cannot be set aside quickly.

Involvement of women. The empowerment of women is not only, as an MDG, a development objective in itself it is also a critical means towards securing sustainable peace. USAID's study of women in post-conflict situations[61] recommends that donors should:

- Build on women's economic and political gains;
- Step up efforts to prevent sexual abuse;
- Promote micro-credit;
- Support implementation of property rights for women;
- Promote greater women's participation in post-conflict elections; and
- Promote practical participation of women.

Women usually have the prime responsibility for the care of children and therefore have the strongest interest in development objectives. However, men are likely to dominate in village organizations, including Parents' Associations and Users' Groups. Accordingly, it may be necessary to support training for women in skills such as public speaking and small business management that will enable them to represent themselves to a male-dominated village committee.

3.4. Conclusions

There is a wide disparity between the three four case studies. Mozambique has performed strongly in relation to MDGs whereas East Timor and Cambodia have been less successful.[62] It would appear that aid can reinforce success, as in Mozambique, but cannot correct deeper political problems as in Cambodia. The relationship with the state is absolutely critical, but generalizations are of little value. Supporting the state was the correct strategy in Mozambique, but, in Cambodia and Uganda, there was a need for more critical engagement and support of alternatives.

Establishing sustainable systems for service delivery requires close scrutiny of the roles of actors at all levels. Indeed, the views of these actors towards service delivery can be seen as an important indicator of their prioritisation of policies, which are pro-poor and supportive of long-term peace. Approaches which separate the transition from relief to development are artificial, particularly in countries which, while emerging from peace, continue to experience areas of re-erupting violent conflict. Building peace requires continued support to sustain poor people during conflict and during their transition to recovery.

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[61] USAID (2001)

[62] 'Success' should not be measured against the base during war, which may have been extraordinarily low as in Cambodia.

In general, donors should be ready to pursue more vigorous pro-poor strategies around the time of peace. Extraneous factors have a tendency to pull in a different direction and need to be handled with care based on firm analysis.

Section Four: Conclusions and Recommendations

4.0 Introduction

OECD Guidelines suggest five key factors in programme design in situations relating to conflict:[63]

- Link the local and the national: ensure sustainability by making sure that in the long run national structures will be able to support local initiatives;
- Decentralised management: Involve local communities and civil society in development planning;
- Integrated approaches: whatever the activity, ensure that its economic and social aspects, especially employment, help to create cohesion;
- Geographical focus: take care not to exacerbate inequalities by ill-conceived targeting of aid; and
- Supporting the reconciliation process: target aid to communities that are making real efforts at reconciliation.

This guidance has some general value but rests on a number of assumptions about the nature of a particular conflict. They are not correct in all situations. Instead they represent median positions that may not be appropriate in extreme cases. Nuanced policy-making can only be based on understanding a specific conflict.

Our case studies indicate that aid managers have tended to regard conflict as an external event, separate from development and reconstruction. When there are prospects for peace they have too quickly lost sight of the issues that caused the conflict. But in fact, such issues are now likely to surface and will strongly influence the nature of the peace.

Aid processes in such situations are characteristically over-optimistic, as if the past had no relevance. In fact, the word ‘reconstruction’ should be abandoned. What existed before the violent conflict may reflect injustices or other factors that were a cause of conflict. The objective should probably be social transformation towards a culture of constructive conflict management. Conflict is in itself a transforming process and will have changed the nature of the society in which it exists.

Each violent conflict contains its own characteristic blend of motives and causes. Some analysts emphasize economic factors and the self-interest of individual actors. Others emphasize the impact of global change on national and local governance. It would be simplistic to characterize a simple forward-moving process in the understanding of conflict. The benefit of the DFID system of analysis is that it simply maps out the different factors leaving the analyst to make judgements about their relative importance.

There is only limited value in dividing the responses into different ‘phases’. As far as possible aid managers should assess their responses and impacts by using a dynamic model of conflict that includes both the elements of Grievance among poorer people, as well as the need to limit the ‘greed’ of predatory elites.

[63] Adapted from OECD (2001) pp133-4

4.1. Opportunities for pro-poor change

Our case studies indicate that there is a very limited window of opportunity for pro-poor change, but this is often ignored in the rush and competition among aid agencies. The danger is that aid will be excessively focused on reconstruction, especially where that means strengthening existing power structures and inequalities.

Mistakes by aid agencies in the period surrounding a peace agreement could be costly in terms of long-term achievement of MDGs. While schools and health posts may be restored to their former configurations of brick and cement, processes of alienation and inequity may have far more profound impacts in the longer term. Our case studies suggest that developing local capacities is an extremely important way of reinforcing peace. Because violent conflict has such negative consequences for poor people they also have a considerable stake in its resolution. It often seems that conflicts continue because they suit elites, and can only do so because poor people are unable to mobilise their influence. This reflects a wider literature drawing on the need to build on local capacities as a response to conflict.[64]

A long-term engagement to support the representation of poor people in decision-making is essential to achieving sustainable peace. As we have noted, this can be through users groups and similar bodies or through local civil society organisations. Such activity cannot be planned on less than a ten-year basis, and yet budgets for reconstruction are commonly conceived as two-to-three years.

4.2. Service Delivery and Peace-building

The relationship between service delivery and peace-building is a complex one. At the simplest level, service delivery is an integral part of peace-building. Yet, in practice, service delivery involves choices and selections. The aid manager who chooses to work in one area may cause resentments in another. The donor who generously supports school construction may be accused of fuelling the corruption that is a central issue in a conflict.

While opportunities for peace-building exist at all stages, the case studies highlight the lasting impact of early engagement in the period when peace is in the offing. This can include efforts to sustain poor people so that they are in the best possible position to represent themselves and also working with officials and political leaders to develop social policies that are pro-poor.

Early in this study we expressed concern about the notion of separating service delivery from peace-building. We suggest that the way forward lies in integrating an understanding of conflict into service delivery perspectives. Peace is likely to be a desirable element in processes of pro-poor change, but cannot be substituted as a goal for MDGs and other clear developmental objectives.

4.3 Sustainable Service Delivery

To be sustainable, service delivery interventions in countries emerging from conflict need to be informed by ongoing conflict analysis and preferably drawn up prior to a peace agreement or settlement. The challenge remains to meet high initial expectations immediately following a peace agreement or settlement with tangible peace dividends and particularly amongst the most excluded areas, while not being diverted from implementing the more far reaching reformation required to ensure enduring pro-poor policy.

[64] Anderson

The major obstacles remain the depletion of national capacity through conflict and the differing individual priorities of donors and national governments. Again, early engagement promotes understanding of conflicting issues and the promotion of coordination in readiness for peace, while the building of capacity during violent conflict preserves and reinforces human resource for subsequent reconstruction.

While there remain risks in direct budgetary support, early engagement by donors enables more accurate assessment of the possibilities to provide regulated support for training and incentives for service delivery staff. Support to superfluous physical reconstruction may not entail the risks of association with a government whose legitimacy is in question, but will divert the limited technical resources available to externally-defined priorities only to put at risk the sustainable provision of services for the poor.

4.4 **Conclusion**

The review makes clear that service delivery interventions impact on conflict. Poorly designed or informed service delivery programmes aggravated existing inequalities in, for example, Cambodia. To promote sustainable peacebuilding, interventions need to be developed through ongoing strategic analysis of the causes of and actors in conflict and development. Such deliberate analysis also enables the identification of indicators to more accurately gauge the positive and negative impact of support provided.

It is clear that early government prioritisation of and commitment to policy reform and allocation of resources for service delivery are critical to development actors. Budget support for service delivery may be a valid option where pro-poor policies are already in place. Reformation of services as countries emerge from conflict provide important opportunities for ensuring the representation of poor people in the formation of service delivery policy, together with strengthening local ownership of these services through ongoing monitoring. Building channels which allow the active participation of women is key to ensuring the effective reach of pro-poor services. The window of opportunity for such reform is, however, limited.

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Annex 1: Case Study Cambodia

Summary of constraints and opportunities emerging from the case study

Service delivery and policies for peacebuilding

- **Reintegration of the factions within the national health service.** WHO supported the Coordinating Committee for health providing a less politicised space for factions to meet and enabling the reintegration of health workers of three of the four factions into the interim health administration.
- **Building national capacity during conflict.** The training of health workers within the Thai/Cambodian refugee camps provided an important resource for later reconstruction, particularly given the depletion of qualified individuals during the Khmer Rouge regime.
- **Guaging readiness for peace.** Donors have been keen to support electoral processes as the channel to resolve differences. However, Cambodia's underlying issues of conflict necessitate wider ranging, long-term address and many areas of reconstruction support did not adequately address existing inequalities.

Sustainable systems for peace building

- Questioned **legitimacy** of national and UN administration. Donors were reticent to work with the transitional authority and SOC-dominated civilian administration and security, while many by-passing UNTAC and SOC/TAC coordination and supporting NGOs at the local level. Lack of engagement with government partners prevented policy reform and standardised coverage of recurrent costs, including social service salaries.
- **Incoherent policies and unequal distribution of resources.** Donors worked outside the coordination regime and negotiated directly with non-communist factions, jeopardising the Accords and UNTAC's mandate. Providing significant resources through NGOs, bilateral donors shaped sectoral policy. The official technical coordination mechanisms had limited capacity to influence the allocation of resources, which was largely decided prior to reaching Cambodia. Assistance was prioritised for the Phnom Penh and the north-west while the north-east and south-west were underserved.
- **Limited funding timeframes** and constricted mandate for political and socio-economic reconstruction. Donor pressure to spend considerable amounts of money in initial reconstruction efforts, together with the restricted time, interpreted mandate and operational capacity of UNTAC, led to a focus on physical reconstruction as opposed to addressing the more critical needs of investment in capacity building.
- **Roles of service providers: Contracting of service delivery.** There have been a number of pilot projects for contracting-in and -out of health service delivery. While there are differences of opinion regarding the most efficient system, both have resulted in improved pro-poor delivery, but need to ensure provincial management and local ownership.
- **Participation: Strengthening provincial and local authorities capacity and empowering local communities.** Centrally designed efforts to promote decentralisation and strengthen provincial and local authorities were less successful than later UNDP support for local management of rural development.

I. Pre agreement (up to 1991)

Conflict issues	Actors
Legacy of colonial urban concentration of resources **Regional and Cold War interests** resulting in the spill over of US bombing in Vietnam and the Soviet/Vietnamese supported invasion. **Imposed structures** and lack of history of resolution through political discussion. Depletion of the skilled work force during the Khmer Rouge genocide**, together with psychological trauma reticent to engage in reconstruction.** **High aid dependency** with economic and social structures varying with the political powers in force	**The Unified Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia (FUNCIPEC)** monarchist supportive of deposed Prince Norodom Sihanouk **The Khmer People's National Liberation Front (KPNLF)** republican. **Democratic Kampuchea, Khmer Rouge** **The three parties joined forces and in 1982 created the Coalition Government of Democratic Kampuchea (CGDK), dominated by the Khmer Rouge, and which held Cambodia's seat in the UN General Assembly until 1991.** **Peoples Republic of Kampuchea**, renamed the State of Cambodia (SOC) in 1990 and subsequently the Cambodian Communist Party (CCP) **Regional actors** China and the Association of Southeast Asian Nations (ASEAN) supported the CGDK **International actors** Former Soviet states supported the Vietnamese-imposed PRK, later SOC government. The US supported the CGDK. Business interests: regional and former colonial.

Policy and practice
While there was a major emergency operation from 1979-1982 in the wake of the Khmer Rouge regime, external assistance was largely limited to emergency relief and rehabilitation pending the withdrawal of the Vietnamese.

In early 1982 the UN declared the emergency over and ongoing international support was principally focused on the 370,000 refugees in camps along the Thai-Cambodian borders. Training of health workers within the camps enabled the development of a pool of qualified staff for the country's future reconstruction. The Khmer Rouge regime had seen the number of doctors and health officers fall from an estimated 462 in 1969 to approximately 50 in 1979.[65]

However, a small number of NGOs and UNICEF continued their work in Cambodia. International NGOs established a coordination mechanism, the Cooperation Committee of Cambodia (CCC). Those NGOs active in health developed in 1989 an informal national coordinating mechanism, MEDICAM, which sought to develop closer relations with Cambodia's Ministry of Health (MoH).

The capacity of the central government to raise taxes was significantly interrupted by the conflict. As government salaries deteriorated below subsistence levels, health workers resorted to private practice to maintain their incomes.[66] There was increased recourse to traditional healers.

[65] Macrae, 2001.
[66] Macrae, 1995.

II. Peace agreement and Transition (1991-1993)
The end of the cold war led external powers to push for an end to the civil war in Cambodia. The Paris Peace Accords of 1991 provided for the creation of the Supreme National Council (SNC), comprising representatives of all the major factions in the country. The United Nations Transitional Authority in Cambodia (UNTAC) was mandated to implement the accords and undertake responsibility for disarming and demobilizing the factions, civilian policing, carrying out elections, civil administration, repatriation, human rights, economic affairs and rehabilitation. Donors pledged more than US$800 in June 1992, far in excess of the UN appeal, to be spent over an 18-month period.

Coverage of service delivery within the agreement
The Accords included a Declaration on the Rehabilitation and Reconstruction of Cambodia, which notes that while rehabilitation could be initiated, "[t]he main responsibility for deciding Cambodia's reconstruction needs and plans should rest with the Cambodian people and the government formed after free and fair elections. No attempt should be made to impose a development strategy on Cambodia from any outside source."[67] The Declaration called for particular attention during the rehabilitation phase for restoration of Cambodia's existing basic infrastructures and public utilities, including health and education.[68]

UNTAC's Rehabilitation Component was guided by the Declarations's three underlying principles of respect for sovereignty, respect for local capacity and ensuring coverage of all areas especially the most advantaged. The SNC's counterpart rehabilitation component was the Technical Advisory Committee (TAC), chaired by UNTAC's Director of Rehabilitation and which sought approval from the factions for all proposed projects with the exception of those implemented by NGOs.[69]

Conflict and policy issues

- **Questioned legitimacy of the transitional government**
- UNTAC unwillingness and incapacity to fulfil all elements of its mandate.
- **Ongoing conflict and mistrust between the factions.** The Khmer Rouge left the UNTAC/SNC framework in 1992 and denied UNTAC access to its zone. Landmines threatened rural security.
- **Unequal concentration of external assistance.** Aid was biased in favour of urban areas, returnees in the north west, and relief.
- **Deficit of skilled workers**
- **Limited time frames.** Rehabilitation support was designed to coincide with the political process. The short implementation period led to a preference for supporting physical infrastructure.

Policies
While UNTAC nominally controlled the highly politicised public administration, its' capacity to do so was, in practice, limited. Moreover, the incumbent CPP regime controlled the bulk of the security forces and the Khmer Rouge was not disarmed.[70]

The World Bank stressed the importance of delivering public services through public administrations and not by NGOs or international agencies. It also cautioned against the creation

[67] Declaration, point 2.
[68] Declaration, point 10.
[69] Lanjouw, 1999.
[70] Brown, 1998.

of parallel but similar programmes for different population groups, such as returnees and demobilised soldiers. However, concerns about the legitimacy of the de facto government prior to elections led many donors to by-pass existing public administration. Yet, there were few officials with the appropriate planning expertise and salaries were plummeting. “At precisely the time when more international assistance than ever before was coming in to the country, the public administration was in crisis.”[71]

The weakness of both UNTAC’s Rehabilitation Component, not fully operational until January 1993[72], and the Technical Advisory Committee (TAC) “reflected the (deliberate) under-investment by donors of the financial and political capital which could have provided a competent coordination regime.”[73] The United States and European donors, including the European Commission, worked outside the coordination regime which they had helped to establish. “Specifically, they sought to direct aid to the non-communist factions and to avoid engaging with the State of Cambodia.”[74] To circumvent UNTAC/TAC, donors also negotiated directly with individual factions for access with the effect of jeopardising the Accords and UNTAC’s mandate.

With relevant multilateral agencies lacking operational capacity, many bilateral and multilateral donors provided support through NGOs at the local level. “Importantly, NGO projects were not subject to scrutiny by the TAC.”[75] In health, for example, “(t)he transitional period saw a rapid expansion of the role of NGOs, ”[76] with close to 70 external organizations involved in the health sector by later 1992. Total funds budgeted for NGOs working in health in 1991 were US$16.6 million, rising to US$28.8 million in 1992.[77] Through direct allocation to operational organizations, bilateral agencies thus shaped sectoral policy.

In contrast to the Declaration of Reconstruction’s call for developing rural areas and building local capacity, much of the assistance was directed through NGOs towards Phnom Penh and the north-west provinces, to which the majority of the refugees sought to return.[78] These NGO interventions were not, however, implemented within a coherent national policy framework and resulted in a highly fragmented pattern of rehabilitation, which did not correspond fully with national health priorities and proved difficult to sustain.[79] The north-east and south-west areas were underserved.

UNHCR and UNDP established a Joint Support Unit with provincial units, primarily in the north west, which aimed to raise the capacity of district and provincial authorities through development of district or community levels projects for repatriated refugees. These provincial units were the forerunners of the UNICEF and WHO-financed provincial health advisors. However, decentralisation did not necessarily result in pro-poor projects. Concerns have been raised that local elites may have dominated initiatives to promote decentralisation, such as school committees. Politicians have also played a strong role in Cambodian education and used schools for political activities.[80] It was also reported that rehabilitation support, together with the reintroduction of a market economy, resulted in increased dependency and villagers being less willing to collaborate without pay for public works.[81]

[71] Lanjouw, 1999.
[72] Doyle, 1989.
[73] Lanjouw, 1999.
[74] Ibid.
[75] Ibid.
[76] Macrae, 1995.
[77] Lanjouw, 1999.
[78] Doyle, 1998.
[79] Lanjouw, 1999.
[80] Ovesen, 1996, cited in Bray, 1999.
[81] Ibid; Kao Kim Hourn.

The national Coordinating Committee for Health (CoCom), established in 1991, included high-level representation from the MoH and international and non-governmental agencies and developed a number of provincial coordination committees (ProCoComs). CoCom's aims were to monitor and evaluate the health activities of international aid agencies. While the majority of donors questioned the legitimacy of public authorities, WHO provided support for the CoCom secretariat, "arguing that the long-term development of effective health services required working with professional staff in relevant ministries and provincial authorities". WHO thus provided a useful and less politicised space for the different factions to meet and discuss the incorporated of their health workers into the national public health system. A key element of reintegration of returnees from the Thai border camps was to ensure that health workers trained in different systems and working with different political factions could be absorbed within the national health system.[82] In November 1993, ahead of a newly mandated government, WHO, along with the interim health administration and with senior personnel from the four political factions of the Supreme National Council (SNC), supported the reintegration and unification of three of the four factions into the existing State of Cambodia (SOC) health services.[83]

Nevertheless, CoCom's capacity to influence internationally financed health programmes was constrained. It has been considered that UNTAC was reluctant to work with the CoCom's chair, Vice-Minister for Health and a member of the Vietnamese backed government. Further, international agencies and NGOs with significant financial support, could have felt encouraged by UNTAC to ignore CoCom's policies and guidelines.[84]

"During the period 1989-1993 the size of the international aid programme in Cambodia increased eighteen-fold from US$17.3 million to US$317 million." No reliable figures exist that detail the precise allocations to health sector during this period. This raises the issues of accountability and subsequent health expenditure planning. What is clear, however, is that by 1993, international aid accounted for 88.6% of total public health expenditure and was unsustainable. "Aid expenditures exceeded government expenditures nearly four-fold in 1992 and more than seven-fold in 1993."[85]

While there were a number of different forms of coordination, none of the mechanisms were linked to resource allocation. "Real decisions regarding the allocation of funds had already been determined prior to reaching Cambodia", resulting in allocation driven more by political and bureaucratic priorities rather than need.

III. Post-conflict Reconstruction (1993-7)

Conflict and Policy Issues

While the 1993 elections were considered technically well planned, they failed to resolve underlying political differences. FUNCINPEC won the elections, but the incumbent CPP was unwilling to handover power. The international community retreated from its commitment to establish a legitimate government and accepted the power-sharing Royal Government of Cambodia (RGC), formed in October 1993. By 1998, little was left of the UNTAC electoral infrastructure.[86]

"In retrospect it was premature to view Cambodia as a "postconflict" society between 1993 and1997."[87] The FUNCINPEC-CPP power-sharing agreement led to the establishment of two

[82] Lanjouw, 1999.
[83] Hun Chun, 1993 cited in Lanjouw, 1999.
[84] Macrae, 1995.
[85] Lanjouw, 1999.
[86] Grube, 1998.
[87] Ibid.

national governments, dominated by the incumbent CPP structures, bloating the bureaucracy, fuelling corruption and further politicizing the security forces.

- **Ongoing conflict in the northwest**, resulted in continued high military expenditure, while there was little progress in supporting a demobilisation programme
- **Lack of political reform.** Security services and the administration remained dominated by the CPP and violations of human rights were prevalent. The new administration failed to reduce the size of the civil service. The First Prime Minister Prince Norodom Ranariddh was ousted in July 1997.
- **The urban bias in economic development** continued, although 80% of the population residing in rural areas.
- **Access to social services remained inequitable** and largely unregulated.
- **High unemployment and continuing low and irregular incentives for public sector workers** leading to informal coping strategies. Donor top up fees for engaging government employees as advisers exacerbated salary differences and weakened existing capacity.

Policy and practice
BWI relations were established with the RGC. The International Committee on the Reconstruction of Cambodia (ICORC) (subsequently replaced by the WB-sponsored Consultative Group Meetings) was established to coordinate international contributions with the newly established government. High dependency on aid coupled with a lack of clear policy framework in a number of areas, led to a number of uncoordinated and unsustainable forms of engagement.[88] Most official bilateral and multilateral aid was focused on economic rather than political development and directed to budget support, infrastructural repair and basic social services.[89]

Critics note that donors "should have made a significant proportion of multilateral aid contingent upon bureaucratic reform, downsizing the army and cessation of timber cutting."[90] Moreover, while donors acknowledged the need for investment in rural development, recognising the risks of unaddressed economic unbalance, efforts continued to concentrate resources around Phnom Penh.[91] Further, while there is increased pressure to assess mine action against broader rural development, such activity is dependent on mine clearance.[92]

Seeking to empower local communities and strengthen the capacity of provincial government, UNDP's initiated the Cambodian Area Rehabilitation and Regeneration (CARERE) project II.[93] This established a chain of elected development committees from the village to provincial level. Budget support was provided to the provinces from which to fund "worthy project" suggested by the villages and communes.

Donors have pressurised the government to enact heath sector reform in order to reduce high levels of aid dependency and inappropriate patterns of provision which have reemerged, in part, because of the process of rehabilitation.[94] Cambodia introduced user-charges in 1997 and has implemented Performance-based Partnership Agreements (PPAs), whereby the government takes advantage of NGOs in contexts where the capacity of the MoH to directly deliver services is limited.[95] Pilot projects for contracting in and out of health provision have been established. While indicating significant increase in service use and decrease in family health expenditure, there are

[88] Hourn, 1998.
[89] Grube, 1998.
[90] Ibid.
[91] Hourn, 1998.
[92] Lawry-White, J and S, 2003
[93] Also know as "Seila", "foundation stone" in Khmer. Doyle 1998.
[94] Macrae, 1995.
[95] Waters, 2004.

contradictions in the findings as to which is the most effective system. These contradictions may, in part, be due to the difficulty of accurate comparisons in an unregulated market, with "as many as 90% of all health care transactions taking place outside the home."[96]

Reaching the most poor: pilot projects for contracting in and Health Equity Funds

A contracting-in pilot project, instituted by HealthNet International in Pereang district, one of the poorest in Cambodia, in 1999, reported "a decrease in total family health expenditure of some 40% from $18 to $11 per capita per year." Despite significantly increased official user fees, constituting 16% of recurrent costs, the utilization of services was equally increased." [1] Decentralised sub-contracting of health facilities was found to be more effective than the individual contracting system, promoting increased local ownership. Fee exemptions were in practice found to reach the well-connected, rather than the poor.

A pilot project to introduce Health Equity Funds, which identify the poor and pay user fees on their behalf, was agreed by Medecins sans Frontieres and UNICEF and undertaken by a local NGO in Sotnikum District in 1999. While the fund appeared to effectively improve access to hospital care of the poor, it does not cover expenses of caring for the patient's dependents while they are in hospital.

Soeters, 2003 and Van de Put, 2002.

"Catastrophic health expenditure is identified as a major cause of indebtedness and destitution among the rural poor.[97] "(E)ven in the absence of fee exemptions for the poor, the existence of a credible public health service considerably reduces out-of-pocket expenditure by the population in general, and the poor in particular."[98] Given the positive initial reports of the contract model, it has been increasingly replicated, despite its long-term impacts remaining unknown. Unregulated self-prescription remains of significant concern.[99]

While most donors suspended approval of new assistance following the ousting of the Prime Minister in 1997, only 5 bilateral donors cancelled or suspended assistance.[100] In mid-1997 the IMF officially terminated its loan agreement with Cambodia. Cancellation and suspension of projects resulted in job losses and the cutting of other related projects not directly financed by the canceling body such as the Consortium for Assistance to Primary Education (CAPE).

[96] Van de Put 2002, cited in Soeters, 2003.
[97] Kassie, 2000 cited in Hardeman, 2004 and Oxfam, 2000.
[98] Hardeman 2004.
[99] Personal communication, 2004.
[100] Grube, 1998.

Annex 2: Case Study East Timor

Summary of constraints and opportunities emerging from the case study

Service delivery and policies for peacebuilding
East Timor provides a context in which a newly independent state is being built. Rather than being used as levers for peace, service delivery could address pre-existing grievances and support nation building.

- **Value of early engagement**. The Conselho National da Resistencia Timorese (CNRT) and World Bank prepared for East Timor's reconstruction, including service delivery, presupposing a pro-independence outcome to the 1999 ballot.
- **Opportunity for reform rather than reconstruction both to promote pro-poor policies and to improve long-term sustainability**. The education sector was able to introduce a number of policies which were pro-poor, including the removal of school and examination fees, the withdrawal of required uniforms and adaptation of the school year to the harvesting cycle. The health sector addressed urban/rural imbalance promoting access through mobile clinics. Policies were based on assessment and regular monitoring. Other critical areas, however, received less attention, including the judicial sector and the civil service structures, anti-corruption and taxation and cost-recovery. The absence of address in these sectors had effects for service delivery, including the recruitment of health professionals.
- Remaining refugees in West Timor, highlight the need for a **regional approach and efforts for reconciliation and justice**. While initial education support in West Timor promoted integration, the size of refugee population overwhelmed local capacity.
- Education as an opportunity for building **national identity**, relating to the issues of language of instruction and replacement of migrant teachers. While young people had played an important role during resistance, there was limited external engagement for secondary, tertiary and non-formal education.
- **Critical nature of justice sector** for all areas of development.

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Sustainable systems for peace building

- The questioned **legitimacy** of the transitional government led to parallel structures with the legitimacy of the United Nations Transitional Administration for East Timor (UNTAET) was recognised internationally while that of CNRT rooted in local support.
- Need for **national counterparts** and early recruitment of national management teams. Early coordination amongst senior national health workers through the East Timorese Health Professionals Working Group, established within days of the conflict, promoted sustainability and a sector-wide approach above short-term delivery.
- Poor communications infrastructure requires **decentralisation** carried out with various successes across sectors. In health, district health plans were early established, while relations between the central and district level are still remote.
- **Pressure for spending during reconstruction.** Public expectation and donor support were high. Yet national health sector capacity was limited and depleted and considerable demands made in responding to donor demands.
- **Complexity of aid financing mechanisms** inhibited national ownership and integration of all sources under a national budget. While the World Bank was able to accelerate preparation of projects, it remained constrained by lengthy procurement procedure.
- **Trade offs between speed of delivery and capacity building.** While there was a need for some "quick wins" in service delivery, implemented through Community Driven

Reconstruction, the absence of agreed policies on wage and local governance created later difficulties. Sectors which promoted policy and institution building over physical rehabilitation involved relatively experienced Timorese counterparts early in the transition. They undertook sectoral planning with donors and maintained information exchange with political leadership while being often less strong initially in achieving physical reconstruction

- **Bridging the gap between relief and rehabilitation.** Donors responded favourably when presented with a comprehensive needs assessment addressing the overlap between humanitarian assistance and reconstruction and demonstrating the importance of simultaneous short- and -long term planning. Humanitarian aid continued well past the start of the principal reconstruction programmes. The health sector rehabilitation and development program enabled international NGO to provide emergency services while the Interim Health Authority (IHA) focused on building longer-term national policy.
- **ECHO promoted international NGO collaboration with the Interim Health Authority.** As a major funder, ECHO agreed ceilings for certain health expenditure in line with the IHA approved district health plans.
- **Participation of the poor**. Local participation was limited and reflected in delayed national capacity building at many levels. While strengthening community capacity to participate in governance issues, a number of the development councils established under the World Bank Community Empowerment Project were dominated by elites. There were efforts to re-establish pre-existing Parent Teachers Associations, but it proved difficult to engage non-health stakeholders in counterpart local health associations. Local NGOs criticized their lack of recognition and support, which, when provided, was largely restricted to project rather than core support. The East Timor NGO Forum, supported by Oxfam, did facilitate cross-regional transfer of experience supporting visits to Cambodia.

I. Pre-1999 ballot

Causes of conflict:	Actors:
Portuguese colonial rule **Indonesian occupation 1975-1999.** A quarter of the 1975 population, approximately 200,000 people, is alleged to have died as a result of human rights abuses during Indonesia's 25 year occupation.[101] Indonesian military and migrant interests resulted in local dispossession of land and exclusion from civil service. The Indonesian army openly supported a number of East Timorese militias of whom some formed as early as the 1970s. Further, not all militias engaged in post-referendum violence were East Timorese. **Inequalities between rural and urban provision of services** with highly centralised systems.	**National** **Revolutionary Front for an Independent East Timor (FRETILIN)**, pro-independence, original body of CNRT. **Armed Force for the National Liberation Resistance (FALINTIL)**, pro-independence, established in 1975 **Conselho National da Resistencia Timorese (CNRT)** umbrella group representing a confederation of local resistance parties. De facto political voice prior to the establishment of independence government. **Catholic Church** with well-established reach and activities. *Local communities**, including local organisations and student groups, played an important role in the struggle for independence.*** **Regional** **Indonesia.** Through its occupation, economic interests linked to the military benefited and consolidated their positions in civil administration. **Australia** supported CNRT planning for independence. **International** **Portugal.** Political, economic and cultural interests.

Policy issues

East Timor was among the poorest areas in East Asia pre-1999, in part as a result of inappropriate and inefficient use of resources under both Portuguese rule and Indonesian occupation.[102] The Portuguese promoted education for the elite, administered by the Catholic Church. Under Indonesian rule, education was used as a tool to conquer with schooling widely available and used to promote the Indonesian language and Indonesian national unity through a highly centralised system. In the early years of occupation, military personnel were teachers in remote areas. Pre-ballot teachers' wages were such that many needed a second job.[103]

Resistance to and co-operation with the Indonesian occupation, together with the post-ballot violence, resulted in multiple identities and social schisms.[104]

[101] Nishikawa.
[102] Patrick, 2001.
[103] Nicolai, 2004.
[104] Nishikawa, 1999.

As a result of the 1997 Asian economic crisis and deposing of President Suharto, Indonesia yielded to the idea of a popular consultation granting East Timor a choice between greater autonomy within Indonesia and complete independence. The United Nations Assistance Mission in East Timor (UNAMET) was established to organise the vote, carried out on 30 August 1999, which resulted in 78% rejection of greater autonomy. The Indonesian-supported pro-autonomy militia initiated waves of violence and infrastructural destruction, resulting in the displacement of some 250,000 to West Timor, amongst whom were a majority of the skilled workforce. The Australian-led International Forces in East Timor (InterFET) was established in September 1999.

The World Bank started to plan for East Timor's reconstruction early in 1999 through analysis and dialogue with East Timorese leadership and the UN, which provided the Bank the possibility to react quickly to the evolving situation.

II. Post referendum and UN Transitional Administration for East Timor (UNTAET) 1999-2002

UNTAET was mandated to administer the territory and exercise legislative and executive authority in preparation for self-government. UNTAET was both the legal government for East Timor and a UN mission, leading to sometimes conflicting aims and difficulties between UNTAET and other development agencies, including the World Bank. There was also some lack of continuity in handover from UNMAET to UNTAET. Further, humanitarian response was provided within both East Timor and West Timor.

Initial efforts to establish a cohesive national policy making body proved unsuccessful. Established in July 2000 with a shared East Timorese/international UNTAET cabinet, the first East Timor Transitional Administration (ETTA) was replaced by a second transitional government following elections for the constituent assembly held in August 2001. That government had a wholly Timorese cabinet, which operated until independence. The Constitution was completed in three months and Presidential elections were held in April 2002. The tight timeframe led to a non-acceptance by many Timorese of the provisions of the Constitution and to tensions between the Presidency and the executive branch of government.[105]

Coverage of service delivery within the agreement

In anticipation of a likely vote for independence, CNRT gathered in Australia in April 1999 to draft a development plan. While the scale of post-ballot devastation led to its abandonment, the plan helped shape subsequent thinking, including within the education sector.[106]

Conflict and policy issues

- **Legitimacy of national counterparts.** The CNRT was not accepted by the UN as the primary legitimate Timorese representative body, although, in the pre-ballot era, the World Bank found the CNRT to be a constructive counterpart. CNRT at first operated in parallel rather than in partnership with UNTAET, at least at the central level, with CNRT's legitimacy rooted in local support and UNTAET's in international law.[107]
- **Widespread destruction and depleted national capacity.** In early 2000, most of the educational equipment and supplies were looted or damaged beyond use, more than 80% of medical staff departed and the central health administration was defunct.[108] The majority of the 5,000 teachers from other parts of Indonesia began leaving in early 1999, with estimates

[105] Schiavo-Campo, 2003.
[106] Nicolai, 2004.
[107] Millo and Barnett, 2003, cited in Nicolai, 2004.
[108] Tulloch et al, 2004.

of between 70 and 80 per cent of senor administrative staff and secondary teachers having departed.[109]

- **Legacies of two previous administrations**, each with its own language and structures, resulting in a resistance to foreign initiated activities and a culture of centralised decision making.
- **Failure to fully draw on pre-ballot community-based structures**, including the Catholic Church.
- **Access to and provision of social services within rural areas** remained difficult, with poor road and telecommunications infrastructure and limited efforts for decentralisation.
- **Absence of a veterans' policy.** FALINTIL fighters were restricted to cantonments prior to the 1999 ballot, but not disbanded until February 2001, when they were then recruited within the new national Defence Force or demobilised. The interim period provided an opportunity to mobilise disgruntled elements of the armed and civilian resistance movement.

General Policy

Due to its pre-ballot planning, the WB was able to respond quickly in 1999 as it launched the Friends of East Timor donor meeting in September and the Joint assessment Mission (JAM) coordinated under the previous UNAMET in October/November. Building on its earlier engagement with the Timorese leadership, this enabled joint planning. The JAM included an equal number of Timorese and international experts and several financing institutions and was carried out concurrent with an IMF mission. Education and health were among the sectors covered within the JAM.

Donor pledging was substantial for both humanitarian and reconstruction activities. Funding for East Timor consisted of six principal sources: the humanitarian consolidated appeal, the assessed contribution budget of UNTAET, two trust funds, namely the Trust Fund for East Timor (TFET) – and sector reconstruction and the Consolidated Fund for East Timor (CFET) – recurrent budget plus development budget for civil service capacity building and justice, UN agency reconstruction programmes and bilateral development assistance through NGOs and contractors. The complexity of funding mechanisms created barriers to national ownership and prevented the integration of all funding sources into the national budget.[110]

Initial lessons drawn from East Timor noted that financial mobilization worked best when donors are presented with a comprehensive needs assessment that addresses overlap between humanitarian assistance and reconstruction financing. Humanitarian aid continued well past the start of the principal reconstruction programmes to prevent gaps between relief and reconstruction. Further, Trust Funds can leverage coordination, but require specific coordination efforts.[111] TFET projects were prepared far more rapidly than "normal" IDA operations.

Efforts to promote coordination and monitor reconstruction included the adoption of a set of agreed benchmarks, reviewed every six months and regular multi-donor joint sector missions. While close discussion between the government and donors promoted shared understanding of sustainability and the recurrent liabilities created through reconstruction projects as well as encouraging timely realization of pledges, aid programming did not always follow national priorities.[112]

[109] Nicolai, 2004.
[110] Rohland, 2002.
[111] Ibid.
[112] Ibid.

Strengthening of national capacity was delayed. UN-financed expatriate experts exercised most regular government functions due, in part, to UNTAET's decision to recruit civil servants from the bottom up.[113] That resulted in the absence of sufficient senior management to support cabinet members or to enable intra-sectoral interaction until late in the transition. While project management units provided useful additional capacity to government-led reconstruction efforts, these were most effective when integrated within departmental structures.

Service delivery: policy in health and education

Facilitated by the existence of an East Timorese Health Professional Working Group (ETHPWG), formed within days of the conflict, UNTAET established the Interim Health Authority (IHA) in February 2000, and together designed the Health Sector Rehabilitation and Development Program (HSRDP). Phase I of this programme allowed NGOs to continue providing essential services while the IHA prepared for longer-term investments through a sector-wide approach favouring integration over vertical programmes. During Phase II the IHA became the Department of Health Services (DHS) and established a national health policy strategy and preventive public health programmes. The DHS also reached agreement with NGOS for each district to formalize district plans. In 2001, under Phase III, the MoH assumed financing responsibilities in most districts and began recruiting health professionals from NGOs and under Phase IV, in late 2001, the NGOS withdrew from districts. The DHS rejected proposals to introduce a contracting system for international NGOs.[114]

There were, within the health sector, the following competing demands and priorities from the public, the political leadership and donors:

Goals	Competing Goals
• Produce measurable results quickly • Disburse funds quickly • Ensure a coherent sector-wide approach • Provide services to all now • Develop health policies soon, before it is "too late"	• Achieve transition to full East Timorese management • Ensure national decision making and full ownership • Focus on building capacity • Ensure sustainability • Accommodate individual donor needs • Improve scope and quality of services • Consult widely on all policy issues • Stay flexible to avoid setting directions "too early"

Competing goals for the health sector from Tulloch et al, 2003

UNICEF took on a quasi-ministerial role for education, while local communities undertook initiatives to resume schooling. By the end of 1999, CNRT had established a voluntary team of central education administrators and begun to establish District Education Committees. The Catholic Church, a large-scale provider of social services in the pre-ballot era, promoted the opening of its own schools and encouraged the local community to open others.

Reconstruction afforded the introduction of pro-poor policies in key social sectors. In education these included the removal of school fees and examination fees, the withdrawal of required uniforms and adapting the school year to the harvesting cycle to reduce drop-out rates of children

[113] Schiavo-Campo, 2003.
[114] Reason for rejection not clarified within Tulloch et al, 2003.

of farm families.[115] The issue of language of instruction entailed competing political and capacity issues. In health, sustainability was addressed from the outset. Redressing the Indonesian structure of overstaffed, underfunded facilities, the HSRDP included the downsizing of the health system provoking strong reaction from some NGOs. ECHO, a major funder of many of the NGOs, promoted close collaboration of international NGOs with the IHA as it agreed to use the district health plans as a basis for funding and also agreed with IHA on ceilings for selected items, including for staff, rehabilitation and drugs.

Practice

There were clear trade-offs between speed of delivery and capacity building. Those sectors which made more progress in establishing policies and institutions involved relatively experienced Timorese counterparts early in the transition. They undertook sectoral planning with donors, maintained information exchange with political leadership and were often less strong initially in achieving physical reconstruction. Sectors which deployed Community Driven Reconstruction (CDR) were able to deliver concrete physical reconstruction outside Dili. They demonstrated the priority the leadership placed on reaching the population most in need. However, the lack of standardised policies within these initiatives, including on wages, caused future difficulties. Unsustainable provision of free services, including electricity, during reconstruction created high expectations and left unpopular decisions for the post-independence government.

Co-sponsored with Portugal and Australia, the World Bank targeted training and information to political leadership (including military leaders) to support the sustainability of reconstruction programmes.[116] Governance within the village development councils, elected within the TFET Community Empowerment Project, was found to be variable as some councils dominated by local elites. While the project did not address the long-term strategy for or relations with local governance, it did strengthen community capacity to participate in local governance discussions.[117]

By April 2000 government health services were established and staffed throughout the country and basic services were restored to most facilities. Major health programmes had been initiated and the main referral hospital had been handed over to national management.

Despite fewer operational schools, UNICEF reported more primary students attending school between December 1999 and July 2000 than prior to the crisis and 734 of the 788 previously-existing schools having been reopened by April 2000. Key factor included enthusiasm for a “Timorese” education and the WFP school feeding programme. Secondary school and non-formal education, however, received less attention. Despite initial voluntary work, UNICEF provided incentives from December 1999 on ward as UNTAET taking over teachers’ salaries from mid 2000. UNICEF also provided incentives for East Timorese teachers providing education for the refugee communities in West Timor.

Local participation was marginalised during the initial humanitarian response, in part due to the absence of key civil society leaders[118]. Parents-teachers associations (PTAs) were re-established and options for strengthening their engagement explored. It proved difficult to establish a health policy development process involving non-health stakeholders.

A huge number of new local NGOs emerged to increase from 34 in January 2000 to 124 in September of the same year. While a number of these new groups lacked capacity and were, in

[115] UN 2000 cited in Nicolai, 2004.
[116] Rohland, 2002.
[117] Ibid.
[118] Bugnion, 2000.

some cases, unrepresentative, some donors were also sceptical about the capacity for pre-existing civil society structures, including both the CNRT and local NGOs. Where local NGOs did receive support, this was, with a number of notable exceptions, focused on project rather than core support. Oxfam's Human Resource Development Programme re-established links with LNGO partners and supported the East Timor NGO Forum, facilitating the visits to other countries in the region, including Cambodia. [119]

III. Ongoing engagement in independent East Timor 2002 to date

Conflict issues

- **Legislative vacuum.** The critical nature of the justice sector for all other areas of development.
- **Continued large inequalities in service provision between urban and rural areas.** Remote relations between central and district level continued in the education structure. East Timor has one of the lowest literacy rates in the world, with sharp divides between the urban and rural areas, at respectively 82% and 37%, and a significant gender imbalance among teachers. [120]
- **Refugees still in West Timor, including a number of former militia leaders.**

Policy and Practice

The United Nations Mission in Support of East Timor (UNMISET) was established following East Timor's independence.

It is estimated that oil and gas revenues provide an exit strategy for external financing.

[119] Patrick, 2001/
[120] UNDP, 2002, cited in Nicolai, 2004.

Annex 3: Case Study Mozambique

Summary of constraints and opportunities emerging from the case study:

Service Delivery and policies for peacebuilding

- **Limited window for change.** Peace settlement provided an important opportunity for reform and change - recognised as necessary even in the absence of major political transition - rather than reconstruction of pre-conflict infrastructure and practice. In some service delivery sectors, such as health, this was seized.

- **Building peace through service delivery.** Through cross-front provision of health and food, NGOs opened up RENAMO areas. Reconstruction efforts focused on less privileged regions facilitated dialogue between government and RENAMO health authorities, facilitating reintegration of rebel areas into a common administration.

- **Building an enabling environment.** Improvement in social service delivery remained reliant on wider infrastructure, including roads, judicial systems and security, underlining the need for a comprehensive, cross-sectoral approach.

- **Guaging readiness for peace.** While Mozambique's peace agreement was reached, in large part, as a result of weariness for war on the part of the parties to the conflict, there remains a need for ongoing assessment of underlying potential causes of conflict and for assistance to respond to these.

Sustainable systems for peacebuilding

- **Legitimacy/Tensions between political and technical objectives.** The desire to re-legitimize the state through delivering tangible peace dividends led to the prioritisation of social sectors over other forms of government presence, but also led to unsustainable, over emphasis on physical reconstruction.

- **Sustainability/Importance of developing social sector policy even before settlement.** Mozambique had developed a health policy even before the signing of the peace agreement. This provided a vital framework for the massive influx of external assistance following the signing of the peace settlement. Health workers also received training through emergency programmes strengthening national capacity to restore services during reconstruction.

- **Legitimacy/Supporting staff incentives in social sectors.** While the Swiss Development Coorporation provided budget support, most donors were reticent to support recurrent costs, particularly salaries. Not only does this affect service delivery, it also obliges social sector staff to develop private forms of income and incites a culture of corruption.

- **Donor financing/coordination of external engagement.** While there was significant donor commitment to support peace building in Mozambique, individual donor priorities prevented an effectively coordinated response and increased pressure on re-emerging government structures. Uncoordinated engagement carried out in politically sensitive areas distorted an already biased health network.

- **Conflicting political and reconstruction timeframes.** The needs and focus within social

sectors did not coincide with the periods of conflict, peace and post-peace settlement. Various forms of health service provision, from emergency assistance to long-term policy planning, were, for example, ongoing both before and after the official peace settlement.

- **Roles of service providers/Channels of assistance.** The types of donor engagement and, in particular, willingness to engage with government ministries and fears of apportioning legitimacy, often conflicted with the social service focus, particularly, in the periods both before and immediately following the peace settlement. WHO played an important role in early engaging with the Ministry of Health. Reliance on international NGOs as channels for supporting service provision further weakened public sector structures.

- **Participation:** There remains limited engagement with civil society and local NGOs have been dissatisfied with their reliance on international NGOs. Donors have made debt relief provided through the enhanced HIPC conditional upon the government's adoption of a participatory poverty reduction strategy.

A Simplified Chronology of the Health Sector in Mozambique
From Pavignani, E and Colombo, A, *Providing Health Services in Countries Disrupted by Civil Wars: A Comparative Analysis of Mozambique and Angola 1975-2000,* WHO.[121]

Period	General	Health-Related
1975	Independence	Nationalisation of health services
1975- 82	Central planning	Health expenditure increases significantly. Primary Health Care (PHC) is adopted and coverages and outputs expand. This expansive thrust suffers from inadequate management capacity and capital shortage.
1982 - 85	Economic crisis and escalation of the civil war	Internal financing is reduced. The National Health Service (NHS) becomes a military target. Coverage contracts.
1985 - 89	Emergency: war, famine, epidemics, and drought. Structural adjustment (launched in 1987). Donor dependence: aid agencies and NGOs pour into the country and take the lead.	Fragmentation of health services along vertical lines. Proliferation of emergency- oriented projects. The NHS, struggling for survival, becomes largely dependent on external aid for its basic functioning.
1990 - 92	Peace negotiations	MoH prepares plans for reconstruction. Sector budget support to provincial expenditure is introduced.
1992	Peace Agreement	
1992 - 94	Transitional period; progressive unification of the country under the same administration.	The rehabilitation of the health network starts. Health services return to previously closed areas. Private practice is reintroduced.
1994	First Democratic elections	
1994 - 99	Progressive normalisation, economic recovery under free-market principles. Decentralisation is endorsed by the government and slowly introduced.	Reconstruction and expansion of the NHS. Skilled health workers (previously concentrated in secure areas) are re-deployed. More qualified and appropriately trained professionals gradually substitute unskilled or low-level workers. Original tools to manage external resources are introduced. Elements of deregulation emerge. The formulation of a new comprehensive health policy is debated without much progress.
1999	Elections: the ruling party is returned to office.	
2000	Cyclones and severe floods devastate swathes of the country.	Large inflow of relief resources.

[121] www.who.int/disasters.hpb/case_studies/mozang.html, 2001, *modified and updated from Pavignani and Durão, 1999.*

I. Pre agreement (1964-1992)

Causes of conflict

Security

Providing sea access to land-locked neighbours, Mozambique is of high regional strategic interest.

The armed struggle for independence gave rise to the 1964-1974 liberation war.

Fears of the Rhodesian colonial and South African apartheid regimes of a successful independent Mozambique gave rise to the 1976-1979 and 1981-1992 wars.

RENAMO recourse to ever more violent activity with the decline in external military support.

Political/economic

Undemocratic government and forced modernisation: The one-party Frelimo government sought to carry out rapid modernisation through centralised planning. Its Marxist policies pursued economic and social reform through nationalisation, villagisation and marginalisation of traditional leaders - policies which were reversed in the late 1980s allowing IMF engagement and leading to significant increases in western aid.

Heavily reliance on income through migrant labour in South Africa and external, particularly Portuguese, investment.

Social

Renamo targeted governmental infrastructure – and in particular schools and health clinics – to undermine government actual and perceived legitimacy. 50 percent of the health infrastructure was completely destroyed and the remaining facilities, in need of repairs and equipment, provided only limited coverage.[122] By the mid-80s the national health service had become totally dependent on external aid.[123]

Existing disparities between rural and urban communities were exacerbated. Frelimo cracked down on religious activity – although this policy was reversed from the mid 1980s onwards.

Actors

National actors

Frelimo: Ready for peace, but took time to accept Renamo as political rather than purely military opposition. Needed to open politically, economically and socially to support the inclusion of those from outside its main support bases and, in particular, the churches and traditional leaders.

Renamo: While ready to halt conflict, Renamo lacked initial confidence to enter peace negotiations. It was not equipped for civilian life and required support to develop into a political party with a coherent ideology and organisational structure. Also required guarantees of security and financial assistance to give up fighting.

Regional actors

Rhodesia established the Mozambique National Resistance (MNR), later known as Renamo, to destabilise newly liberated Mozambique and counteract Zimbabwe's liberation forces. Its supporters included Frelimo dissidents and soldiers who fought with the Portuguese during the liberation war.

Zimbabwe, landlocked, leant military forces to support Frelimo and stabilise the Beira corridor, its principal sea access.

South Africa took over support to Renamo following Zimbabwe's independence in 1980, in continued efforts to destabilise Mozambique's independence government and destroy South Africa's liberation movement, the ANC.

Tanzania provided military support to Frelimo and hosted 60,000 refugees. **Botswana** supported peace negotiations, a key actor among the Front Lines States opposing apartheid South Africa.

Kenya initiated discussion and sought to host a peace process, but perceived as biased towards Renamo. **Malawi** permitted Renamo bases until 1986 and hosted up to 1 million refugees.

International actors

France supported Frelimo and provided military training to post-agreement army.

[122] Keane 1996, from Pavignani and Colombo, 2001.
[123] Noormahomed and Segall, 1992, from Pavignani and Colombo, 2001.

	Reflecting Cold War interests, **the USSR and East Germany** supported Frelimo, while **West Germany** supported Renamo. The UK provided military assistance and aid to Frelimo and dissuaded the US from supporting Renamo. **Portugal** was key base for Renamo and private business maintained significant interests in Mozambique. They were particularly keen to be involved in peace negotiations to ensure the return of those assets loss through Frelimo nationalisation. **The World Bank** accorded Mozambique its first loan in 1985, with IMF economic recovery and structural adjustment programmes introduced in 1987 and 1989. **Lonhro** extensive investments in Mozambique and its Director, "Tiny" Rowland, played a major, personal role in peace negotiations and also "funded" Renamo continued compliance with the peace agreement. **The Catholic Church**, the largest supra-ethnic organisation in Mozambique, was a key actor in initiating discussion between the parties to the conflict. The **Italian** government hosted and financed the peace talks, led by the Sant'Egidio lay catholic community.

- **Policy issues**

The provision of humanitarian assistance within the ongoing conflict raised important issues with regard to decisions to work through national or international channels, security, perceived accordance of legitimacy through selection of channels and areas of assistance and coordination.

Guiding principles for humanitarian assistance were agreed in July 1992 to enable freedom of movement to meet the humanitarian needs arising from the devastating drought, but were, in practice, often disrespected. Access to those in need remained difficult and there was widespread manipulation of aid.

- **Policies practised**

EC and UNHCR, among other large agencies, channeled significant resources through NGOs, particularly for health[124]. The number of international NGOs rose from 7 in 1980 to 180 in 1990,[125] while that of national/local NGOs rose from 4 in 1984 to over 200 in 1996.[126] Under pressure for quick delivery, criteria for funding were relaxed with little monitoring and evaluation. NGOs, engaged largely in individual projects rather than under national guidelines, threatened the

[124] Macrae, 1995.
[125] Hanlon, 1991.
[126] van Diesen, 1999.

development of a coherent system.[127] Health services split along vertical lines, according to donor-funded (and partially donor-controlled) programmes. At the beginning of the 1990s, the MoH encouraged some donors to "adopt" provinces, which led to further fragmentation[128].

War destruction devastated the rural health network to strengthen the pre-war bias. Investments benefited safe areas, along important transport lines, creating greater imbalances, attracting people from RENAMO-controlled areas to internally displaced camps and enhancing the government position. RENAMO areas received limited humanitarian assistance due to its inability to negotiate external assistance and fears of consolidating its position.[129]

As their autonomy vis-à-vis the MoH increased substantially, NGOs went where the donors wanted them to, although donor choices influenced often more by political and military considerations rather than health-related needs. While NGOs (particularly those involved in food distribution) played an important role in opening up RENAMO areas and cross-front health activities contributed to decreasing tensions and to dismantling military control on people movements, the impact of health interventions is controversial. NGO resources might have substituted for local ones with little information of their overall effect available.[130]

The government, supported by WHO and the World Bank, attracted coordinated donor support by establishing a solid information base and developing a realistic health policy by 1991-2, **even before the signing of the peace agreement.**[131] Reconstruction plans for the health sector promoted equity, affordability and sustainability **acknowledging that major changes would have been required even without the war**. Early forward planning provided a realistic framework for external engagement in reconstruction. However, a number of key actors did not coordinate with the Ministry of Health (MoH) and invested in politically-sensitive areas. The latter created serious distortions in an already biased health network and over stretching MoH capacity. Furthermore, no advantage was, at this stage, taken in drawing lessons learned in other countries.[132]

II. Peace agreement and post-conflict reconstruction (1992-1996)

General conflict fatigue coupled with the devastating drought of 1991-92, the end of the Cold War and the apartheid regime in South Africa enabled a ceasefire to be reached relatively quickly. The signing of the General Peace Agreement (GPA), reached on 4 October 1992 required extensive negotiation and significant injections of cash to buy the parties, especially RENAMO, into the political process.

The peace process covered transitional government with UN administration in the period leading up to the multi-party elections, extensive security sector reform and the withdrawal of foreign troops.

The UN and international community, keen on a success after recent operations in Somalia and Angola, were willing to invest heavily in peace. The UN Operations in Mozambique (ONUMOZ), established in December 1992, defined a wide mandate encompassing political, military, electoral and humanitarian components. Humanitarian activities were coordinated through the UN Office for Humanitarian Assistance Coordination (UNOHAC). Being integrated within peace keeping structures, its tasks included reorienting humanitarian activities to include RENAMO areas,

[127] Macrae, 1995.
[128] Pavignani, 2004
[129] Pavignani and Colombo, 2001.
[130] Ibid.
[131] Pavignani, 2004, citing Noormahomed and Segall, 1992.
[132] Pavignani, 2004.

supporting the reintegration of demobilised soldiers and mine clearance programmes. UNOHAC developed a Consolidated Humanitarian Assistance Programme covering both relief and rehabilitation, a forerunner of the UN Consolidated Appeal (CAP). While overshadowed by the political and military components of the UN Operations in Mozambique (ONUMOZ) and subject to UN agency rivalries, UNOHAC field offices were considered effective in supporting local level reconciliation.[133]

Coverage of service delivery within the agreement
At the initial donor conference in 1992, implemented in accordance with Protocol VI of the GPA, a total of US$520m was pledged, above the sought US$400m, to finance demobilisation, reintegration of the internally displaced and refugees and the activities of the political parties.

Health policies had been agreed prior to the agreement. The economic and social reintegration of demobilised soldiers was specifically covered within Protocol 4 of the GPA implemented through joint planning.

Conflict and policy issues

Legacies of conflict included a fear to return to rural areas, the destruction of commercial and productive facilities and the threat of landmines

Conflicting peace policies. There were tensions between a realistic approach to policy discussion – which acknowledged capacity and resource limitations – and a political approach, keen to emphasise progress with peace.[134] "Mozambique's successful emergence from conflict has been in no small part due to its success in relegitimising the state … through a strong commitment to re-establishing and delivering basic services", with the focus on restoration of education and health care.[135] Politically-charged reconstruction, however, exceeded capacity. "(F)or the government it was a political statement of legitimacy and continuity; for RENAMO, a way of gaining recognition as administrator of unserved areas; for donor agencies and NGOS, the most visible strategy to justify their presence in contested areas".[136] Some have also considered the aid provided to sustain the peace process and assist returnees as "excessive" in relation to needs.[137]

Weak government partners and incoherent policies. The selection of implementing partners remained an issue. The impact of practices initiated during the immediate post-peace settlement underlies present conflicts of interests.

High aid dependence. The country remained highly dependent on external aid. From 1994-99 Mozambique was the largest single recipient of foreign assistance in Africa (amounting to US$4.7 billion) carrying with it a high presence of external aid management[138] and greater accountability to donor as opposed to national demands.[139] The IMF Structural Adjustment Programme resulted in a sharp fall in GDP and fuelled unemployment, despite the end of the war. Corruption increased as civil service wages experienced sharp cuts. SAP restrictions prevented the government from directing credit to rural areas and buying bad debt and covering equipment destroyed through

[133] Pavignani and Colombo, 2001.
[134] Pavignani and Durao, 1999; Pavignani, 2004.
[135] DFID, 2001.
[136] Pavignani, 2004.
[137] Hall, 1998, cited in Pavignani and Colombo, 2001.
[138] Pavignani, 2002.
[139] Montes, 2000.

conflict, as well as preventing some essential reconstruction projects for example. Protests by donors and the Mozambican government led to easing of restrictions.[140]

Pre-existing inequalities and domination by urban elite continued. In education, for example, Portuguese, the language of the urban elite, continued as the language of instruction.

Practice

The transition from conflict to peace was much harder than anticipated. As displaced populations returned home or settled in new areas, new demands on the health system resulted in delays in the expansion of delivery. Reconstruction was slow, with roads often impassable due to land mines and disrepair. Health workers were reluctant to leave urban areas. As populations returned home, their access to the existing health facilities decreased. In 1995, under-five mortality rate had actually increased to 270 per 1,000 (from 269 per 1,000 in 1991).[141] UNHCR focused on Quick Impact Projects (QUIPs) in areas resettled by returnees. Returnees were in some cases reluctant to return to areas lacking sufficient basic services, particularly schools. However, QUIPS were directed to those areas in which there were already returnees.[142]

Weak government capacity resulted in much EC aid being channeled through international NGOs. An analysis of the EU support to the health sector between 1992 and 1996 concluded that of the US$ 80.5 million sector contribution, 53% was channeled through NGOs.[143] External assistance to health focused on material input and physical infrastructure with minimal support for recurrent costs and, in particular, salaries.[144] The government was left with many empty infrastructural shells, which remained closed.[145] Monitoring of this assistance has focused on 'physical' results rather than impact.[146] Management issues predominated MoH activity resulting in uncoordinated donor-led initiatives in areas, including management and financing reform, which lacked clear MoH policy.

Most bilaterals consulted closely with MoH proposals, while most UN agencies plainly ignored them. "Those agencies with a prescriptive strategy elaborated by headquarters and/or with a short mandate were more likely to see" the government as an obstacle.[147] Neither UNHCR nor the EU fully accepted the coordinating role of UNOHAC nor, despite lacking in-house technical capacity, did they establish close relations with the MoH.

The government remained reticent to raise user fees, while the reduction in health workers' earnings encouraged the pursuit of unregulated compensating strategies leaving health care for the poor at the discretion of the health worker.[148] While other donors were reticent to support recurrent expenditure, the Swiss Development Cooperation (SDC) provided budget support from 1990 on ward. This not only enabled the expansion of services, but also strengthened the information system, which allowed the monitoring of reconstruction. Despite its central role in supporting the MoH and emergency health response in the late 80's, WHO failed to play a major role in post-conflict health sector reconstruction.[149]

[140] Hanlon, 2000, and War Torn Societies Project, 1995.
[141] Pavignani 2004, citing Keane 1996.
[142] Dolan, 1999.
[143] Colombo, 1997, cited in Pavignani and Colombo, 2001.
[144] Macrae, 1995.
[145] Colombo, 1995; Hallam, 1997.
[146] Montes, 2000.
[147] Pavignani and Durao, 1999.
[148] Pavignani, 2004.
[149] Pavignani and Colombo, 2001.

Reconstruction efforts were, however, focused on rural areas and less privileged regions, in an attempt to tackle existing imbalances in service provision.[150] By 1996, health service use in rural areas increased three-fold from two years earlier.[151] UNOHAC was instrumental in facilitating the dialogue between the MOH and RENAMO health authorities. The former warring parties allowed NGOs to revive health services in RENAMO-controlled areas, whose population had been excluded from access to formal health services. The political significance of this indirect collaboration between hostile sides was remarkable. Retraining of health staff from RENAMO areas demonstrated MoH willingness for building peace. As health facilities were opened in RENAMO areas and the only available professionals were in government areas, "RENAMO authorities came progressively to accept health workers from outside, first employed by NGOs and eventually by the MoH. The whole process powerfully contributed to the progressive reintegration of rebel areas into a common administration."[152]

A number of commentators consider the recovery of Mozambique's health sector "a visible success, spearheading and giving credibility to the whole peace process."[153] "(T)he expansion of health services prioritised neglected or previously inaccessible areas, people were exposed first to the state as service provider, receiving a tangible 'peace dividend'. Civil administration, police, army, taxes, arrived in remote districts well later than health services, schools or boreholes." [154] The 1995 National Education Policy sought to increase equitable access, quality and relevance of teaching and to reinforce capacity building of the Ministry of Education. Moreover, the need for using regional Mozambican languages as the languages of instruction has been recognised.[155]

The government, nevertheless, continued to meet hostility in the same areas most benefiting from reconstruction.[156] Cautions have been raised of the risk of frustration and social unrest where rehabilitation projects lacked exit strategies to ensure financial and institutional sustainability.[157] NGOs became involved in areas such as demobilisation, demining and support for elections, which were not (at least in Mozambique) NGO traditional fields of intervention.[158] Further, NGOs in some cases, established new forums for beneficiary populations (Development Councils), considered unsustainable and unlikely to have a positive impact on governance.[159]

III. Ongoing engagement in conflict-prone (1997 – present)

Key indicators
Population: 16.1, of which 45% aged 14 or under and 71% live in the countryside.
Literacy: 60% of people aged 15 are illiterate, 50% of Mozambicans between 15 and 19 are illiterate and 76% of women are illiterate.

Large number of female-headed households due to conflict and migrant labour.

14.5% of the population were estimated to have HIV at the end of 1998. Life expectancy is anticipated to fall from 43.5 year in 1997 to 35.4 years in 2010. In 1997 it was estimated that by 2002 there would be over 400,000 orphans as a result of AIDS.

1997 data, Hanlon 2000

[150] Pavignani and Colombo, 2001.
[151] Waters, 2004.
[152] Pavignani, 2004.
[153] Pavignani and Colombo, 2001.
[154] Ibid.
[155] Tawil, 2004.
[156] Pavignani and Colombo, 2001.
[157] Montes, 2000; EC Evaluation of Actions Financed under Article 255, VII EDF, 1997.
[158] Pavignani and Colombo, 2001.
[159] Montes, 2000.

Conflict issues

Political marginalisation and slow decentralisation: There remains a need to develop constructive engagement within government policy making and decentralisation of resources, including to pro-Renamo areas. Local opposition has developed, but there remain no other viable national political parties. Government engagement with civil society remains limited and local NGOs have been dissatisfied with their dependence on international NGOs. While the need for Mozambique's regional languages to supersede Portuguese as the language of instruction has been recognized,[160] Portuguese and English are thriving and native languages are being marginalized.

Increasing disparity between the rich and poor: While Mozambique's per capita income remains among the lowest in the world, and over two-thirds of the population live below the national poverty-line, there are distinct regional differences. GDP per capita in 1999 showed US $162 for the north and US $ 189 for the centre, compared to US$ 471 for the south and US$ 1,426 in Maputo City. BWI policies and private investment focused in the Maputo corridor are resulting in increased rural marginalisation. Frelimo and the Catholic Church have warned of these widening divides.

Economic vulnerability: While Mozambique's dependence on aid has fallen to 20% of GDP, such dependency is still high. This creates huge stakes in the competition over access to state resources. The legal and regulatory systems remain weak and corruption remains prevalent. In 1999 the National Health Service relied on external aid for 50 percent of its recurrent and 90 percent of capital expenditures.[161]

Flooding in 2000 was met by effective response, although there are concerns that the resulting focus on rehabilitation may weaken development plans.

Policy and practice

Despite widespread privatisation, the state remains the principal provider of health and education, particularly in the rural areas. Public sector reform is underway in a number of sectors, with a movement towards sector-wide approaches (SWAPs), including for health and education. Implementation of policies remains curbed by weak government capacity particularly within regional structures. Donors remained reluctant to focus on the extremely low remuneration of government employees, which resulted in a continued heavy reliance on external technical assistance. Weak capacity has been further heightened by donors' use of semi-autonomous project management units and widespread use of salary top-ups to government officials recruited to work on their own projects with incentives or through consultancies. Such donor practice weakened the same ministries, which aid was designed to strengthen.[162] While donor competition weakened efforts to tighten management and introduce stricter controls, the 2000 Code of Conduct, the Kaya Kwanga Commitment, agreed principles for pursuing a health sector-wide approach.[163]

MoH and donor relations have been strained due to past over-intrusion on the part of a small number of donors. An analogy aired by a MoH representative held: "dealing with donors was like trying to drive a taxi with the owners sitting in the back: they are all sure they want to get somewhere but they can't agree where and if the driver doesn't take them to the right place they won't pay the fare… At the same time, however, there is a healthy realism… from the driver about

[160] Tawil, 2004.
[161] Pavignani and Durao, 1999.
[162] Montes, 2000.
[163] Brown, 2000.

the donors' unwillingness to get out of the taxi altogether. There is a view in MoH that Mozambique is seen as an attractive success story by the international community who will want to continue to be associated with it." [164]

The World Bank and EU, among other donors, have sought to increase consultation with civil society and pushed for more inclusive governance. Debt relief through the Enhanced HIPC Initiative was, for example, conditional upon the Government's adoption of a participatory poverty reduction strategy. While the government prepared the action Plan for the Reduction of Absolute Poverty (PARPA), it was not considered sufficiently participatory. A number of creditors granted additional debt relief following the 2000 floods.

Evaluation of EC aid

EC engagement suffered from weak lines between the country analysis and unfocused strategy with limited consultation between donors and with civil society. There was found to be "very little analysis of the nature and causes of poverty and no analysis of how the strategy proposed is an appropriate means to reduce poverty." Based on population density, EC aid focused on Zambezia and Namula. The EC Rural Health system Rehabilitation in Zambezia was appropriately targeted – the province with the lowest Government health spending per capita in 1998 and supportive of the emerging sector-wide approach, but was severely delayed. However, overall, the EC Rural Development Programmes were found to lack successful impact. While peace-building was included within the 'complementary sectors', support to strengthened governance was limited to support for elections and central government structures.

Evaluation of EC country strategy, 1996-2000, Montes, 2000

[164] Brown, 2001.

Annex 4: Case Study Uganda

The case of Uganda demonstrates restoration of pre-conflict service provision during initial reconstruction and, subsequently, the introduction of more fundamental, pro-poor reform. The ongoing conflict has resulted in tiered national development and heightened pre-existing inequalities.

Summary of constraints and opportunities emerging from the case study

Service delivery and policies for peacebuilding:

- **Efforts focused on restoration rather than reformation.** There were significant achievements in a number of areas, including juvenile justice and social welfare policy, benefiting both national provision and, subsequently, important within post-genocide Rwanda. However, rehabilitation of the health sector focused on infrastructure and vertical programmes, which legitimised the government, tangibly demonstrated peace and government reach, but failed to build longer-term sustainability.
- **Engagement in areas of ongoing conflict promoted return and provided a channel for communication with central government and international development,** e.g., health work in West Nile.
- **Community involvement promoting reconciliation.** An unanticipated positive outcome of health rehabilitation was that where the community was involved in rehabilitation of local health services, this promoted reconciliation.
- **Failing to target the underlying causes of conflict.** Ongoing conflict in northern Uganda has heightened the historical inequalities in development and service provision compared within southern districts. Regional and continuing rural/urban differences demonstrate the need for ongoing monitoring of the continuing risks of conflict.

Sustainable systems for peacebuilding:

- **Depletion of qualified staff and low incentives**. Many qualified staff had left Uganda prior to 1986. Those who remained were isolated from international policy development and suffered low, irregular payment. This situation continues within ongoing areas of conflict in Uganda where it is difficult to ensure posts are filled.
- **Political priorities and donor time frames unsuited to rehabilitation.** High expectations meant that the government put considerable emphasis on quick delivery. Donors' short project cycles for rehabilitation echoed this. Weak national technical capacity and government reluctance to challenge the bureaucracy's status quo left concerns over the need for wider reform unaddressed.
- **Economic reform promoted over political reform and tackling of corruption.** Social development was assumed to follow from economic recovery without tackling the inequalities and inefficiencies of pre-conflict structures. Donors were keener to impose economic as opposed to political conditionalities. Yet, without political channels, armed oppositions groups reemerged or were newly recreated.
- **Service providers/sustainability in situations of extreme poverty.** Relief and rehabilitation programmes, which provided for recurrent costs, particularly provision of drugs and salaries, resulted in increased user rates, the transition to development and removal of support for recurrent costs leading to decreased use. Low incentives continue to result in significant difficulties in maintaining qualified staff in northern districts.
- **Participation.** Local monitoring of public expenditure on education, through a central government mass information campaign, resulted in significant decreases in 'leakage'.

I.Pre-1986

Conflict issues	Actors
Ethnic divisions exploited during colonial rule; security forces drawn from northern groups, Baganda nationalism. Inequitable provision of social services **with colonial urban bias** **History of extreme violence,** particularly under Amin and Obote's second period in office. **Widespread physical destruction** **Depletion of skilled work force**, particularly under Amin **Political patronage of the public administration** resulting in a bloated, corrupt and inefficient bureaucracy	**National** **Uganda People's Congress (UPC**) led by Milton Obote **KabakaYekka** and **Democratic Party**, Bagandan. **Idi Amin** seized power in 1971. Expelled Uganda's 80,000 Asians in 1972 and seized their assets. **National Resistance Army (NRA)**, and later, National Resistance Movement (NRM), led by Yoweri Museveni, southern constituency **Holy Spirit Movement**, precursor of the **Lord's Resistance Army (LRA)**, led by Joseph Kony. **Regional** Tanzania **supported Ugandan exiles from the Amin regime and, following an attack in 1978, Tanzania launched a major counter offensive and overthrew the Amin government in April 1979.** **Sudan** has and continues to support armed opposition groups, including the LRA. **International** **Britain.** Former British colony and significant economic interests.

Policy and practice

Until 1970s, the Ugandan population enjoyed better health status than its African neighbours with nearly three quarters of children immunised against some of the killer diseases. Primary and secondary education was characterized by a pupil-teacher ratio that was 25% below the African average in 1960.[165] There was, nevertheless, an urban and regional bias in the provision of services favouring the central, southern and eastern parts of the country, while the other areas and especially the north under served.[166] Moreover the national health system focused on urban and curative care resulting in poorer provision for the rural population.

The expulsion of the Asian community and violence of the Amin regime resulted in considerable depletion of experience personnel. "(T)he number of doctors registered in the country fell from 978 in 1967-68 to 564 in 1979, and pharmacists from 116 to 15."[167] Education systems were disrupted, which led to fewer qualified individuals. Financing of the public health system diminished, as low salaries encouraged informal charging of goods together with an increased reliance on private provision. "In 1988 it was estimated that about 50 per cent of healthcare was

[165] Warnock and Conway,
[166] Carlson, 2004.
[167] Macrae, 2001.

provided by the missions."[168] By 1986/7 the Ministry of Health (MoH) budget was just 6.4% of its 1970 amount in real terms.[169]

A number of international NGOs operated during the 1981-86 civil war and particularly in the Luwero Triangle.

II. Reconstruction 1986-1992:

Conflict issues

- **Not post-conflict.** Despite initial political will for reconciliation and the formation of an inclusive government, certain areas continued to experience conflict exacerbating existing inequalities and leading to continued high proportion of government expenditure on defence.
- **Inequitable access to social services** and focus on restoration of pre-conflict provision rather than reform.
- **Widespread corruption** and smuggling

Prioritisation of social services

The social sectors were not priorities for the NRM government's political programme outlined in its 10-point plan. The plan provided for the rehabilitation of the social and health infrastructure, but assumed that social development would follow in the wake of economic recovery.[170] The NRM had executive secretaries for defence and education, but none for health. Neither health nor education was identified among the eight priorities of the 1989 economic recovery programme.[171] Defence continued to account for more than one-third of public expenditure in 1988/9.[172]

Policy issues

Government capacity was extremely limited and the country's infrastructure and economy shattered. The bureaucracy was bloated and corrupt, the one used by previous regimes to reinforce state powers. Only in 1992, with the Government's Rehabilitation Plan, was a clear mechanism for sectoral development instituted.

In 1986, the UNICEF representative in Uganda outlined two broad policy options for the health sector, i.e., restoration of its pre-1970s levels, or more radical redefinition to meet equity and sustainability objectives.[173] The World Bank's First Health Project also prepared a set of reports, which warned of the hazards of a physical as opposed to an institutional approach.

Despite cautions raised over the longer term sustainability in restoring pre-conflict health structures, together with the need to address inequitable distribution of resources, the Government's 1987 Health Policy Review did not emphasise the need for fundamental restructuring. Hence, "[t]he restoration of the health infrastructure was perceived at all levels to symbolize a process of normalisation and part of a wider process of Uganda's return to its pre-1970 situation, with high expectations and the provision of health services widely seen as a government responsibility."[174]

[168] Annet and Janovsky 1988 cited in Macrae, 2001.
[169] Macrae, 1996.
[170] Ibid; World Bank, 2003, Waters 2004.
[171] Macrae, 2001.
[172] Ibid.
[173] Dodge cited in Macrae, 1996.
[174] Macrae , 1996.

Efforts to instate legitimacy through restoration of pre-conflict structures, were coupled with medical professional interests in maintaining the status quo and government cautions on challenging this, together with a lack of capacity for technical debate as a result of the country's isolation from international health discussion and senior expertise having fled the country's conflict.

Further, the short time frame of donor project cycles for rehabilitation favoured rehabilitation over recurrent expenditure and significant external engagement prior to the development of national policy. Major health needs, such as malaria, were not prioritised by donors.

Practice
World Bank technical assistance to build national capacity for economic management and to restore the confidence of private business promoted Uganda's economic recovery. It also supported the demobilisation and reintegration programme. However, external engagement was less successful in ensuring that economic recovery was equitable or pro-poor.[175]

Rehabilitation of the health service reinforced the pre-conflict urban bias of service provision concentrating resources on physical infrastructures. The absence of central government policy led to disparate external engagement, with divisions both geographically and by facility. This complicated coordination and led to donor-led prioritisation of government financial and organisational capacity.

Services were largely implemented through programmes, which ran parallel to the government health system.[176] While there were a high number of expatriate technical advisers, only limited training was provided to MOH staff particularly at the district level. External technical support within and outside the national health-related ministries was largely linked to the implementation of specific types of programmes or geographical project areas, which resulted in a number of micro policies and preventing the development of national health policy and sectoral budget.

Seizing the window of opportunity for policy change; building and transferring national capacity; and scaling up of pilot projects

While UNICEF 'adopted' the Ministry of Health, and came to be seen as the 'alternative' MoH, Save the Children UK (SC UK) established the then Department of Probation and Social Welfare in the Ministry of Relief and Rehabilitation. So close was the association that it used to be referred to as Save the Children, even though it was part of the ministry. SC UK also supported the development of the national social welfare policy and the child law review. However, a number of the central systems and area pilots, which SC UK established, while themselves successful, were not sustained or replicated at the central level.

SC UK's work in building capacity through its involvement with government ministries and area projects in Uganda was to prove vital to the organisation's early engagement in post-genocide Rwanda.

Support from the World Bank for health and education rehabilitation was unconditional. However, only an estimated 37% of education investment reached the schools.[177] Despite the warnings of its own reports about the need for institutional reform, World Bank support for health rehabilitation was largely linked to the supply of drugs and physical rehabilitation. The legitimising function of

[175] Kreimer, 1998.
[176] Macrae 1996.
[177] Kreimer, 1998.

this aid was prioritised over its sustainability. Investment in the Expanded Programme of Immunisation (EPI) was rightly a health priority, but also served an important political function demonstrating the government's national reach.[178] The relative dominance of this and other vertical programmes, over their integration with routine and basic health delivery and bypassing of district/local health facility systems, has been seen as a negative outcome of the rehabilitation process.

	Positive	Negative
Anticipated	Physical rehabilitation of infrastructure Improved immunization coverage Improved supply of essential drugs	Relative dominance of vertical health programmes Limited capacity building
Unanticipated	Physical rehabilitation as basis for community participation and reconciliation	Proliferation of projects rather than strategic national health policy Limited institutional development at national and local levels Unsustainable escalation in recurrent costs High levels of aid dependency Poor coordination and inequitable distribution of aid resources Skews service provision in favour of selection interventions and urban areas

Summary of outcomes of health rehabilitation programmes[179]

Achievements in health rehabilitation were difficult to gauge, given the lack of baseline data. Physical rehabilitation in depopulated areas, such as West Nile, provided an incentive for people to return home. NGO engagement in areas experiencing ongoing conflict enabled the health sector to regain contact with international health developments. An unanticipated positive outcome was that where communities participated in the rehabilitation of the physical infrastructure, these programmes also contributed to reconciliation. However, not all rehabilitation programmes built in community involvement and in 1996 community participation in health management remained relatively underdeveloped.[180]

The Government published its National Health Plan in 1991 with a budget four times the available resources. Aid accounted for 62% of health resources in 1990-91 and by 1998 this figure remained unchanged.[181] The government was initially reluctant to implement user charges and unrealistic assumptions about the rate of economic recovery and the ability of the government to take on recurrent costs created high levels of dependency on external aid. Donor investment was particularly high for primary health care and, in poor areas, such as Soroti District, when rehabilitation support, including salaries for health staff, was reduced and service fees were introduced (from 1990). This resulted in the low utilisation of public services and the sustained privatisation of health service provision. [182]

III. Ongoing engagement in a conflict-prone context 1992 to date

Conflict issues

- **Limited political participation** and representation within central government. The lack of political parties has resulted in the emergence or re-emergence of a number of armed

[178] Macrae, 1996 and 2001.
[179] Macrae, Zwi and Gilson, 1996.
[180] Nalwanga Sabina cited in Macrae 1996.
[181] Save the Children Fund 1993 cited in Macrae 2001.
[182] Macrae, 2001.

groups. Apart from the LRA, they have included the West Nile Bank Front (WNBF) and the Allied Democratic Front in the south-west.
- **Cross-border conflicts.** Ugandan involvement within conflicts in neighbouring states has led to support for armed opposition groups within Uganda and continued, large-scale internal displacement within northern districts.
- **Continued high military expenditure** due to engagement in neighbouring DRC and ongoing instability in the north.
- **Failure to address historical and growing inequitable development** with northern districts being unable to benefit from developments occurring in the south and west of the country.
- **Widespread corruption** with conflict looting diminishing the urgency of sustainable address.

Policy issues
Even in conflict affected areas, communicable diseases kill far more people than those who are killed through violence.[183]
Prevalence of HIV/AIDS[184]
High dependency on international assistance.
Need to support staff to continue working in insecure positions.

Policy and practice
While donors widely praised Uganda's economic achievements, they have more recently criticized the government's failure to resolve the ongoing conflict in the north and question its interventions in the DRC.

The World Bank supported the government's Northern Ugandan Reconstruction Project (NURPI) to begin in 1992. It aimed to redress existing inequity in recovery and restore economic and social infrastructure. While unable to address the widespread needs or address the ongoing causes of under development, its most successful components were those entailing substantial community involvements.[185] NURPII includes a Social Action Fund (NUSAF) designed to promote local capacity to identify needs.

Health service delivery in northern Uganda remains heavily reliant on international NGOs and faith-based organisations. Rural health services in much of the northern districts have closed due to violence and looting.[186] Staff have been reticent to stay in their positions due to low salaries and better conditions and opportunities elsewhere. Health centres in areas experiencing conflict, such as Kitgum, are extremely understaffed.[187] A number of NGOs, including SC UK in West Nile, have provided incentives to promote retention of health workers.

The government has shifted budget allocation away from supporting the main tertiary hospital in Kampala to supporting district primary care. From 2000, much health funding has been channeled through a SWAP or through direct budget support, although some major donors continue to provide project support. While welcome, decentralisation of health services was carried out abruptly and without sufficient planning, leaving district staff without systems or training support.

[183] Walley, 2004, p3.
[184] HIV rates are higher in northern Uganda –7.9% compared to a national average of 6.9% (2003), Walley 2004.
[185] Ministry of Finance, 2003.
[186] Carlson, 2004.
[187] Walley, 2004, p7.

Museveni included free primary education within his manifesto for May 1996 election, the first presidential election since the military takeover in 1986. A mass information campaign has enabled greatly improved local monitoring of central government resources.[188]

> In 1996 a public expenditure tracking survey of local governments and primary schools revealed that only 13 percent of the per-student capitation grants made it to the schools in 1991-95. Most funds went to purposes unrelated to education or for private gain and the survey resulted in indictments of district education officers. To enable schools and parents to monitor local expenditure, central government began a mass information campaign. It published data on monthly transfers of grants to districts in newspapers and broadcasted them on the radio. It required primary schools and district administrations to post notices on all inflows of funds. From 1995-2001 all schools experienced a large drop in leakage, and most particularly amongst those schools with access to newspapers.
>
> *World Development Report 2004, Making services Work for Poor People*, The World Bank, 2003

[188] World Bank, 2003

Annex 5: TERMS OF REFERENCE

SERVICE DELIVERY IN COUNTRIES EMERGING FROM CONFLICT

(Revised: March 24)

1. Background

1.1 The Service Delivery in Difficult Environments (SDDE) team is composed of staff from Policy Division's Service Delivery and Poverty Reduction in Difficult Environments teams, and the Conflict and Humanitarian Department. The overall purpose of the SDDE team's work is to produce guidance on mechanisms and levers for service delivery in difficult environments that facilitates the creation of coherent institutional arrangements and promotes social and political pro-poor change.

1.2 The objectives of the team's overall work plan are as follows:

Objective 1: Review the existing literature and experience in order to find out what mechanisms and approaches appear to offer the best prospects for delivering basic services in difficult environments, which also lead to sustainable service delivery and which promote pro poor social and political change.

Objective 2: Conduct a series of country case studies to examine examples of approaches to service delivery in difficult environments that have been tried out on the ground and to understand their longer term impact on institutional capacity and pro poor change.

Objective 3: On the basis of the evidence, develop policy options for service delivery in difficult environments and test their application with relevant DFID country programmes, regional policy units, international partners, non-governmental organisations, and other stakeholders.

1.3 To meet these overall objectives, it has been decided that the SDDE team should focus part of its efforts on service delivery in countries emerging from conflict. This is partly due to an ongoing and increasing interest across Whitehall and elsewhere in the international community in developing knowledge on how to support effective post-conflict reconstruction in a variety of contexts. Furthermore, countries emerging from conflict constitute a substantial sub-section of those contexts understood to present "difficult environments". In discussions with teams working on such countries, such as Sudan and DRC, mechanisms for service delivery have emerged as an important issue.

1.4 Outputs around this work will therefore be focused on lesson-learning and the identification of key approaches and considerations for audiences in DFID regional and country teams, other policy division teams, and potentially any future IPCR unit (and preceding mechanisms). They will also be highly relevant to our work with other bilateral and multilateral partners.

1.5 There are a number of ways of looking at service delivery in countries emerging from conflict. There are recurring questions in discussion around countries in or emerging from conflict about how humanitarian or developmental aid to service delivery might be used to provide support to efforts to generate a political settlement (e.g. Somalia), to support ongoing processes (e.g. DRC), and embed settlements once they have been reached to promote avoidance of future conflict and that the impact of conflict on institutions and poverty reduction is addressed. There is a need to explore the anecdotal evidence that prioritising particular services has produced "positive externalities" beyond the meeting of an immediate service needs and the reconstruction of

infrastructure because of their political significance, broader economic benefits or impact on particular groups.

1.6 There is also a need to examine the ways in which internal efforts and reforms and external humanitarian and developmental assistance can promote the creation of sustainable indigenous systems for service delivery that are effective and accountable.

2. Objective:

2.1 To examine the service delivery in countries emerging from conflict from two perspectives:

(1) the strategic role of service delivery in promoting social and political pro-poor change towards the avoidance of future conflict; and

(2) strengthening institutions in countries emerging from conflict strengthening sustainable service delivery systems in countries emerging from conflict.

3. Scope:

3.1 It is proposed that the SDDE team commission external consultants to review experience to date in this area in two phases, the first covering section a) of the objective and the second on section b). Each phase will focus on the choices made by internal and external actors and what lessons can be learned about the impact of those but also contextual factors that led to them being successful or otherwise.

3.2 In order to make the review manageable, it is proposed that we 'centre' this retrospective review on a small number of countries. These have been tentatively identified as: Cambodia, East Timor, Mozambique and Uganda. However, these may be adjusted or revised as judged appropriate during the course of the study by agreement between the Consultants Team and DFID.

3.3 For phase one, the review will look at what choices were made with regard to the prioritisation and improvement of service delivery as the country emerged from conflict; what informed (e.g. an understanding of the causes of the conflict) those choices and what was the impact not only on the delivery of those services, but, more importantly, for the purposes of this phase, on efforts to establish the legitimacy of the peace settlement, restoring more meaningful linkages between state and society post-conflict and reducing the incentives to return to conflict (e.g. by the production of tangible peace dividends for the population or key groups).

3.4 Phase two will focus on systems for service delivery. It will consider how the choices made and mechanisms used for delivering services in countries emerging from conflict have affected the long-term sustainability of service delivery systems. For the purpose of this phase, the services considered may be limited to health and education, though other services may also be considered if this is practical and useful within the time and resources available. This phase will examine the experiences and lessons learned in relation to:

- the choices made regarding when and if the emphasis of effort is given to reform or reconstruction of systems
- the level of analysis and information needed to make these choices
- the balance and sequencing of efforts to enable the basic needs of the population to be met whilst sustainable systems are being built

- the relative roles of actors (e.g. national state, UN agencies, donor agencies, INGOs) in this process and the affects of their programmatic and institutional objectives.

4. Conduct of work

4.1 The consultants will require expertise in both conflict prevention and recovery as well as good appreciation of service delivery and poverty reduction in developing countries, and access to other experts in this field.

The review will be conducted by drawing on existing literature on these issues, particularly grey literature emanating from activities in the countries identified, and interviews and consultations with relevant individuals and organisations with experience of these contexts and issues, in the UK and Geneva.

The consultants will consist of a small core team of three or four experienced experts who will be responsible for carrying out most of the work. In addition, up to two additional experts with direct experience with service provision in countries emerging from conflict will contribute to the work by reviewing drafts and participating in review meetings.

As part of the work, the consultants will arrange a workshop (of approximately 10 – 15 participants) in London to examine key issues and initial findings from the work.

5. Output

The output for each phase will be a report (of no more than 20 pages plus an executive summary and possible annexes) that synthesises the findings on the key issues outlined in the scope. The reports should provide evidence and examples from the experience in the countries identified

6. Timing

The work should take place between 1 April 2004 and January 2005.

7. Reporting

The Consultants Team will report to Dr. Owen Greene at CICS. Quality Assurance for the work will be the responsibility of the University of Bradford.

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