Aid Coordination Mechanisms for Reconstructing the Health Sector of Post-Conflict Countries

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Abstract
Some trends have been observed in international assistance for the reconstruction of the health sector in countries that have suffered a conflict throughout their entire country. The authors, having pursued aid activities in Cambodia and Afghanistan and reviewed past experiences, propose useful aid coordination mechanisms for post-conflict countries. The mechanisms include the establishment of a national coordination group between the recipient country’s Ministry of Health, donors and NGOs, sub-coordinating groups for specific technical topics, and coordination groups at the provincial level. Additionally, the involvement of NGOs, such as umbrella NGOs, is indispensable to the reconstruction process. Although aid work sharing and the participation of military forces in reconstruction activities may be necessary under certain circumstances, we still need to examine strategies to include them. Consequently, it is time for the international community to integrate aid activities for post-conflict countries in order to respond immediately and effectively to their immediate needs.

Key words Post-conflict, Afghanistan, Cambodia, Aid coordination, Health

Introduction
The past several decades have been characterized by a series of conflicts around the world as witnessed in the countries such as Cambodia, Kosovo, East Timor, and Afghanistan. Obviously, the violence resulting from conflicts increases morbidity, mortality and disabilities.1 Conflicts are most likely to destroy a country’s health system or undermine the quality and availability of public health care owing to paralysis in decision-making, budgetary deficits, and low morale among government workers.2 Rebuilding the health care system is not an easy task,3 especially in post-conflict countries where the entire country has been devastated, such as Cambodia and Afghanistan. Immediate and coordinated international support expedites the reconstruction process.

The increase in conflicts since the 1950s has increased opportunities to assist afflicted countries.4 As Launtze and her colleagues5 point out, internal and external organizations (such as civil society organizations, UN agencies, donors, non-governmental organizations, and international organizations) have been criticized for recurring difficulties in coordinating such activities. The international aid community, therefore, needs to learn from its experiences, formulate concrete aid strategies on coordination for post-conflict countries, and establish an international system for providing guidance and technical and policy advice to fledging governments emerging from conflict.6 Kreczko7 extracted elements from experiences in Afghanistan to propose an aid framework for how international donors should provide humanitarian assistance to post-conflict countries facing complex emergencies. However, his framework did not include the necessary
specific mechanisms for implementing activities in the field.

There are some potential difficulties with coordination, including, 1) how to create ownership by the Ministry of Health (MOH) and to develop the capacity of the MOH, 2) how to communicate national policy to the peripheral level, 3) how to coordinate donors and external experts, and provide advice from external actors to the MOH, 4) how to include NGOs in policy making, how to develop the capacity of local NGOs, and how to coordinate with NGOs, and 5) how to coordinate humanitarian activities with other actors, such as military forces.

The authors of this paper have pursued health reconstruction efforts in Cambodia and Afghanistan and witnessed some trends in health aid. Based on our involvement in health assistance and a review of earlier reports in other post-conflict countries including Rwanda, Uganda, Somalia, East-Timor, and Kosovo as well as Cambodia and Afghanistan, this paper describes the type of coordination activities and mechanisms required from the international aid community in post-conflict countries, and examines: 1) the participation of national and local governments, 2) the MOH and donor coordination, 3) NGO involvement, 4) the involvement of other actors.

Table 1 summarizes reports on the seven countries covering coordination groups, membership of the coordination group, issues, lessons, and recommendations. From these experiences, we tried to extract meaningful common mechanisms for better coordination. In addition, we tried to identify useful approaches from the lessons learnt and recommendations received from different countries, although some of the details were unclear due to deficiencies in the reports.

Experiences

Health coordination groups—Coordination mechanisms between the government and donor agencies

Over the past several decades, the number of actors involved in the reconstruction of post-conflict countries and their collaborative efforts have increased. Our review shows that some coordination efforts were implemented in many post-conflict countries, However, the methodology is neither clear and nor established yet, and there is still a trend for individual actors to initiate their own activities and for coordination not to always occur immediately.

Coordination groups at national level

In many countries there is a coordination group at the national level, and NGOs usually participate in this group. However, the Ministry of Health (MOH) is neither always included, nor strengthened. In Uganda in the 1980s, the Health Policy Review Commission was formulated to coordinate actions among the recipient country and donors. However, it served to present financial aid for the programs of expertise and the interests of donors and failed to seek to enhance the policy-making capacity of the Ugandan MOH. In the case of Rwanda, the UN Rwanda Emergency Office (UNREO) was set up before the establishment of the new transitional government, and its roles were preparing and elaborating discussion and policy papers, overall information collection, supporting UN agency operation, and assuming the role of secretariat for the donor meetings. After the establishment of the new transitional government, UNICEF initially concentrated on supporting the new government to re-establish functioning ministries, and it expected that the government, rather than UN agencies, could play its coordination role. However, technical coordination was outside of mandate of UN field coordination capacity, and UNREO’s ability to provide authoritative leadership and effective management coordination was limited. Instead, two largest donors within the international communities led initiatives. Consequently, the technical coordination mechanism was unclear, and Rwandan ownership was not promoted.

Even in the countries that have no MOH, efforts to involve local representatives from the different factions can be tried to foster the ownership of the recipient countries. In Kosovo, limited local ownership was observed in the initial policy formulation process for “Interim Health Policy Guidelines”. In this process, newly formed health policy-working group appointed by Department of Health and Social Welfare of UN Mission in Kosovo (UNIMIK) was involved, however, the weakness of ownership was recognized by WHO and UNIMIK, and some representatives from the different factions were added into this health policy-working group. In Somalia, a mechanism for aid coordination was
### Table 1 Coordination mechanisms in different post-conflict countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Coordination group (CG)</th>
<th>Membership of CG and their role</th>
<th>Issues/Features</th>
<th>Lessons/Recommendations</th>
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<tr>
<td><strong>Uganda (1987)</strong></td>
<td>Yes (Health Policy Review Commission)</td>
<td>Expatriate technical advisors working with MOH, including NGOs</td>
<td>• Little enhancement of policy making capacity at government level.</td>
<td>The government should play a coordinating role.</td>
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<td>Cambodia (1992)</td>
<td>Yes (CoCom: Coordination Committee at national level, ProCoCom: Provincial Coordination Committee at provincial level)</td>
<td>Members: MOH &amp; external donors, NGOs (national &amp; international) Chaired by MOH Role: monitoring and evaluating all health activities • advising MOH • making recommendations to MOH</td>
<td>• An umbrella NGO (MEDICAM) existed, with a seat in CoCom. • Introduction of subcontracting to NGOs.</td>
<td>UNTAC worked according to the three key principles of sovereignty, respect for local capacity, and balance of assistance for all areas.</td>
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<tr>
<td>Rwanda (1994)</td>
<td>Yes (UNREO: UN Rwanda Emergency Office)</td>
<td>UN agencies Role: preparing policy papers • collecting, disseminating information • supporting UN agencies • acting as secretariat for the Disaster Management Team, NGO, and donors</td>
<td>• Technical coordination was incomplete. • Responsibility for technical coordination lay outside UNREO’s mandate. • UNICEF, WHO etc., maintained responsibility for technical coordination individually. • Authority of coordination by UNREO was unclear. • Two largest donors made initiatives. • UNICEF initially concentrated on supporting the new government.</td>
<td>The government should play a coordinating role.</td>
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<td>Somalia (1994)</td>
<td>Yes (linked with UNOSOM: UN Operation in Somalia)</td>
<td>External donors, UN agencies, NGOs, and Somali factions</td>
<td>• Local NGOs were not included in UNTAET. • Umbrella NGO, East-Timor NGO Forum was formulated. • Utilization of Local NGOs in sub-contracting and training roles was conducted through Community Empowerment Program</td>
<td>The lack of involvement of local NGOs was criticized as a new form of colonialism.</td>
</tr>
<tr>
<td>East-Timor (1999)</td>
<td>Different form (INTERFET → UNTAET → Interim health authority) because of no existing government</td>
<td>UN and International NGOs</td>
<td>• Interim health policy guidelines were established. • Policy working group was appointed by the Department of Health and Social Welfare for making ownership (but, Serbian medical community was not successfully included).</td>
<td></td>
</tr>
<tr>
<td>Kosovo (1999)</td>
<td>Yes (health policy working group)</td>
<td>Policy working group composed of Kosovo Albanians, with technical assistance from WHO Consultative meeting with local/ international medical communities</td>
<td>• There is no umbrella NGO, however, there is an informal voluntary network. • Subcontracting to NGOs to run provinces and districts was widely introduced. • Donors and NGOs who support specific activities (such as nursing school) have responsibilities for specific sectoral and geographic areas. • Military forces participate in health development activities</td>
<td>The roles of various key actors should be defined early. • WHO can play the lead role in health policy development. The lead policy organization should concentrate on policy development and coordination, and support the process of its implementation.</td>
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<td>Afghanistan (2001)</td>
<td>Yes (Local CGHN: Local Consultative Group for Health and Nutrition at national level, PCC: Provincial Coordinating Committee at provincial level)</td>
<td>Members: MOH &amp; external donors, NGOs (national &amp; international) Chaired by MOH Role: monitoring and evaluating all health activities • advising to MOH • making recommendations to MOH</td>
<td></td>
<td></td>
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</tbody>
</table>
established, which was linked with UNOSOM (UN Operation in Somalia) as an independent unit, to build legitimacy both nationally and internationally through an ongoing process of dialogue with the different Somali factions, international donors, UN agencies, and NGOs. However, it was ended due to the subsequent breakdown in the security situation and the withdrawal of UN forces.

In Cambodia and Afghanistan, on the other hand, the Ministry of Health has had a strong coordinating role, and has established effective partnerships with UN agencies, donors, and academic institutions. In addition, the MOH allocated major donors to key underserved rural areas, and used major NGOs to deliver primary health care packages in Afghanistan.

The Coordination Committee (CoCom: this name was subsequently changed to Technical Working Group for Health.) in Cambodia and the Local Consultative Group for Health and Nutrition in Afghanistan as a coordination group at national level, progressed with the ownership of the two countries respectively. The major advantages in the case of both countries were that the representatives of the MOH chaired the group and were the major actors in decision-making, and that donors played the role of advisors to the MOH.

A coordination group at the national level should function to support policy-making that encourages the active participation of a recipient country in the process, and strengthens the capacity of its MOH. Such a national coordination group will enhance the ownership and initiatives of a recipient government in the reconstruction process.

Sub-coordination groups under the national coordination groups for technical issues
A national coordination group often faces difficulties in dealing with specific health issues, and its members are not always familiar with all technical issues. Thus, sub-coordination groups under the national coordination groups in which the MOH technical staff and aid agency advisors attend, can be useful for discussing specific health policies and submitting technical reports or recommendations to the national coordination group. Smaller-scale working groups under sub-coordination groups may also be effective for discussing further detailed issues and topics.

Table 2: Topics of sub-coordination meetings

<table>
<thead>
<tr>
<th>Cambodia</th>
<th>Afghanistan</th>
</tr>
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<tbody>
<tr>
<td>Personnel</td>
<td>Human resources</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td>MCH</td>
</tr>
<tr>
<td>Other</td>
<td>Health economics</td>
</tr>
<tr>
<td>Total</td>
<td>10 topics</td>
</tr>
</tbody>
</table>

One matter that should be noted is that topics to be discussed at the sub-coordination groups should be selected based on the needs of a recipient country and not based on the political will of donors, as this may weaken donor coordination.
We observed one case in which a donor tried to establish a working group which would discuss almost the same topics as other groups, in order to seize the political initiative in that field.

**Coordination groups at provincial level**

Coordination at the provincial level has also been little reported on, except in Cambodia and Afghanistan. In Cambodia, the Provincial Coordination Committees (Pro-CoCom; this name was also changed to Provincial Technical Working Group for Health) were established to support the local governments’ implementation of national policies, and advisors from UNICEF and WHO worked with provincial health departments under this scheme (see Fig. 1 for the coordination mechanism in Cambodia). In Afghanistan, the process is underway to establish Provincial Coordinating Committees (PCC). Such collaborative arrangements are effective for coordinating donor support of health reconstruction at the provincial level.

Humanitarian agencies in countries such as Kosovo, Afghanistan, and Iraq are increasingly facing the need to work closely with, and even be coordinated by and support the capacity of, national government or quasi-state entities. Our review of initiatives in some post-conflict countries indicates that coordination mechanisms at the national and provincial levels are indispensable in rebuilding the health sector.

**Involvement of NGOs**

NGOs have been important actors in reconstructing the health sector of post-conflict countries, and three types of participation mechanisms have been notable in providing assistance. Considering their advantages, the international aid community must include NGO participation as a component of future aid strategy.

**Involvement of NGO in coordination groups**

To benefit most from the collaboration of NGOs, the recipient government, and donors, a specific mechanism is required. The mechanism needs to function to convey the opinions of NGOs to the MOH and the aid community as well as the national policies and other relevant information to NGOs. The first type of mechanism is for the NGOs to have some seats in coordination groups at the national level and also at the provincial level.

In many countries that we reviewed, NGOs had opportunities to participate in national coordination groups, sometimes individually, and sometimes as representatives of an umbrella NGO. At the same time, it is important that local NGOs should not be neglected. For instance, the involvement of only international NGOs was criticized as a new form of colonialism in East Timor, when local NGOs were not included in the national coordination groups. In this way, NGOs’ views can be reflected in health policies, and the policies can be implemented at the grass-roots level.

**Umbrella NGO**

The second mechanism is an umbrella NGO or NGO network in post-conflict health reconstruction efforts which can support the above functions.

In the case of Cambodia, an umbrella organization, MEDICAM, which coordinates various...
health NGOs, was created, and its representative received an official seat in CoCom. MEDICAM has performed the functions described above, and through this organization, the MOH and donors have been able to gain knowledge about NGO activities. In East Timor, the East Timor NGO Forum was formed as a local NGO umbrella body, reflecting a desire to shift donors’ priorities and seeking to realize the vision of local NGOs playing a necessary role in the process of democratization. In Afghanistan, a formal umbrella NGO has not been established, although there has been an active voluntary network of NGOs, and several major NGOs involved in this network have participated in Local Consultative Groups.

**Subcontracting NGOs**

The third type of mechanism is subcontracting to NGOs. As Loevinsohn and Harding have noted, this type of work sharing may be especially useful in countries, whose health service system has been devastated and whose public health administration capacity is at a minimum, due to factors such as a shortage of health personnel and decimated health facilities as a result of a conflict.

This type of mechanism was observed in Cambodia, East Timor, Afghanistan and other countries. In Cambodia, some NGO subcontracting was attempted in running local governments, national health facilities, and programs. In Afghanistan, the Performance-based Partnership Agreement (PPA) was drawn up as a way of subcontracting to NGOs. In addition, the NGOs and donors in charge of supporting specific institutions in Afghanistan, such as nursing schools in specific areas, were selected and subcontracted (Fig. 2).

Some problems have been observed, however, with regard to subcontracting to NGOs. The first is ownership. Humanitarian agencies are increasingly being forced to work where no legitimate government exists, resulting in the increasing independence of agencies from local authorities. The second issue is related to brain drain. In one example in Cambodia, some local NGOs, with financial support from a donor, hired skilled MOH personnel, and consequently government services deteriorated due to a drain of the necessary resources to the NGOs. In a subcontracting process, care must be taken to ensure that subcontracted NGOs will not obstruct the empowerment of the recipient government. A third issue is the sustainability of local health administration. Local and international NGOs in Cambodia and Afghanistan, with funding from donors, have played a primary role in health service provision on behalf of the local governments. However, some or all of their activities may need to be handed over to the local government when funding ends. Thus, in consolidating an aid strategy for post-conflict countries, there is a need to develop a clear plan of how the withdrawal of donor funding and the transfer
of NGO activities to the local governments, in addition to the empowerment of the local governments, should be achieved.

In evaluating the effectiveness of NGO subcontracting, therefore, it is necessary to assess the contribution of NGOs not only in improving health indicators in their field of responsibility but also in strengthening the capacity of local public health institutions, as well as national health systems. The capacity building of a recipient country’s public health sector must be prioritized in aid efforts. Without an empowered public sector, the health system will neither be developed nor sustained when international post-conflict assistance terminates.

Other aid coordination trends and issues
As discussed above, many new attempts have been implemented to assist post-conflict countries. In Afghanistan, two additional forms of activities have been observed and they have indicated important issues for donors in formulating an effective health aid strategy for post-conflict countries.

Stratification of aid
In Cambodia, each donor agency usually provided a comprehensive aid package to health facilities that included the reconstruction of buildings, the provision of equipment, and the training of local human resources (Fig. 3-1). However, in Afghanistan, donor aid was rather more stratified, with each donor supporting an aspect of assistance, resulting in multiple donors performing their own aid activities and contributing to a joint health aid package for a health facility. For example, one aid organization renovated hospitals or health centers, while other agencies provided equipment, and others trained their staff. In this way, one health facility was supported by various aid agencies (Fig. 3-2).

This stratification of aid activities, or aid work sharing, may have been due to the limited capacity of each donor or the restricted scope of aid schemes.

However, the stratification of aid creates some problems. One of the side effects of stratification is that aid agencies, especially bilateral donors, often face difficulties in generating domestic political visibility in supporting a particular health organization and may become reluctant to provide assistance. It can also cause imbalanced aid. For instance, some facilities received assistance for building reconstruction but for neither equipment nor training.

To avoid this imbalance, in Afghanistan, some donor agencies assisted building renovation only when equipment was made available by other donors. To implement aid stratification more efficiently, a coordination model was formulated in the field of nursing education as a joint project by various agencies. One NGO that is assisting a nursing school in Kabul and Japanese-side as a donor agency agreed on a collaborative effort and generated an aid stratification format.
whereby the NGO would train nurses, the donor agency would renovate facilities and provide equipment and some budgetary support, and another selected local NGO would support the management of the nursing school (HIS; Institute of Health Science) in one province. The MOH approved this work sharing format and intends to replicate it in eight nursing schools. The effectiveness of this format model needs to be examined. Once its benefit has been verified, it should be included in aid mechanisms so that the model can be replicated as an aid stratification strategy in other post-conflict countries.

The participation of military forces in aid activities

Another feature of aid to Afghanistan is that military forces have participated in aid activities. The participation of military forces in aid activities is not new, and has been observed in a series of recent emergencies in Afghanistan, Somalia, the Balkans, and Iraq. Previously the role of military forces was mainly to maintain order. However, the U.S. military forces and the International Security Assistance Force (ISAF) in Afghanistan have served not only to help maintain order but also to reconstruct health related-facilities such as hospitals and medical schools.20

Furthermore, many American-led civil and military provincial reconstruction teams are working to rebuild hospitals and schools, provide drugs and equipment, and even deliver clinical services, and medical specialists of the U.S. military forces have been conducting clinical training in Afghanistan as well.6 Actually, the main obstacle to reconstruction programmes is the security situation.21 Especially in the early stage of reconstruction efforts, aid activities tended to concentrate on the capital and surrounding areas owing to poor security in rural areas.9 This tendency was also observed in Cambodia, and the reconstruction process was delayed in rural areas as well. Therefore, the deployment of military assistance may be effective for the speedier reconstruction of rural areas.

However, the direct participation of military forces in the health sector makes it difficult to distinguish aid organizations from armed forces, and aid workers can be more easily targeted by anti-government forces.21,22 Recent events actually show that foreigners, including international aid workers, are being targeted by antigovernment fighters.23 In addition, some NGOs are not in favor of military participation in humanitarian activities and have even rejected participation in aid activities conducted under the supervision of peacekeeping authorities.24 The participation of armed forces is therefore a controversial issue. The international community should clarify the role of military forces in humanitarian assistance and endeavor to promote an environment in which aid agencies do not have to be restricted in their activities for security reasons.
Conclusion

Aid agencies have accumulated experience in reconstruction of the health sector in post-conflict countries. What we need for future health assistance is not individual action by different donors but coordinated action by the international aid community. It is time for the international aid community to evaluate aid in the light of the trends and activities identified above, and agree upon a strategy of integrating individual competencies into coordinated assistance mechanisms, in addition to a broad framework. We suggest development of coordination mechanisms, as one method to help post-conflict countries rebuild their health sector. NGOs, including local NGOs, should be involved in this process. Although some issues still remain, we believe that such a consensus will allow a quicker, more effective and systematic response to the rebuilding of war-torn countries, and that these coordination mechanisms can be useful to other developing countries.

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References