Demand and supply of technical assistance and lessons for the health sector

Issues and challenges from rapid country reviews

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This paper seeks to provide a practical grounding in actual country experience of technical assistance (TA) to help inform the discussion of current issues in its use. It does this by synthesising a number of issues related to TA emerging from rapid field work in four countries undertaken by researchers familiar with the country context, using a common framework of enquiry into the use of, and attitudes towards TA.[1] The conclusions of this work were written up as country perspective notes (CPNs) covering Tanzania, Sierra Leone, Uganda and the Solomon Islands, alongside a brief analysis of TA issues from Ethiopia. The country explorations reviewed specific examples of how the demand for TA is articulated and how the supply of TA is responding. The resulting notes demonstrated the commonality of both opportunities and constraints despite the diversity across the countries.

This paper presents a brief review of the key concepts of capacity development and technical assistance; considers how context plays a role; and outlines the analytical framework that was applied in the country investigations. It then sets out findings emerging from the country reviews, organised into three levels of analysis: TA issues beyond the sector; TA at the sector level; and the operational deployment of TA.

1. The nature and definition of technical assistance

The term 'technical assistance' covers a great deal, and different development institutions often work with similar and overlapping definitions. The usual focus of TA interventions - improvements in 'capability', 'capacity', 'skills' and/or 'performance' – covers a similarly wide-ranging set of definitions and conceptualisations. The focus of the TA intervention can itself be wide-ranging. Interventions may focus on improving the ability of specific key individuals, or it may have a wider focus on increasing the function of certain teams, whole systems and even entire organisations.

'Technical assistance' can be aimed at delivering different objectives that impact individuals, systems and organisations:

- Capacity substitution/gap filling – the use of TA to undertake tasks and duties that would normally fall to a regular member of staff
- Capacity supplementation – the use of TA to provide time-limited advice and guidance for existing members of staff, often on particularly challenging areas of decision-making. All organisations make use of this.
- Capacity development – the use of TA to explicitly transfer skills, knowledge and capability to permanent staff members.

Capacity development is often seen as the most sophisticated and developed form of TA, since it aims for the TA to hand over responsibilities to, and ultimately exit from, national institutions. Even within this category of TA, there are important differences – although not necessarily strict divisions – between certain types of intervention, for example:

- 'Hard' technical interventions – the delivery of specific technical training and knowledge to skilled professionals in a particular field (e.g. training to clinicians on new medical techniques). This may include the installation of new systems and procedures (e.g. new HR management procedures and associated staff training) as well as training personnel.

[1] These are critical areas where international development partners need to change their behaviour in order to accelerate progress on the MDGs that were identified at the IHP+ meeting in Nairobi, December 2012. http://www.internationalhealthpartnership.net/en/news-events/ihp-news/article/seven-behaviours-how-development-partners-can-change-for-the-better-325359/. Behaviour seven refers to TA: 'Provision of strategically planned and well-coordinated technical support'.

- 'Soft' skills development – training and knowledge transfer designed to enhance non-specialist capabilities across entire systems and organisations (e.g. training to senior managers on people management, corporate strategy and/or high-level organizational planning).

Across all forms of TA, there are a number of different approaches to the delivery of the intended capacity effect. The concept of a counterpart can be considered in terms of individuals, teams and systems although in the development field it has most commonly referred to individuals. Such counterparts refer to specific individuals within national organisations who are paired with external advisers with the explicit understanding that one should learn from the other. In contrast, team counterparts are the groups of people with whom the TA works to build capacity across teams.

As well as the diversity of approaches noted above, TA can also be implemented very differently in terms of time frames and levels of ambition. Within the country reviews there were examples of day-long trainings delivered by a single "fly in, fly out" consultant; through to long-term TA projects involving a large number of resident technical assistants delivering coordinated interventions as part of a programme that will last many years. Some TA projects involve widespread (and intentional) use of international staff, whereas others explicitly attempted to use only local staff.

As can be seen, the concept of technical assistance can therefore cover a wide range of activities that are delivered in a number of ways for a variety of purposes. The main point is perhaps to note the importance of clarity on what type of TA is under consideration at any one time, so as to be sure that the debate on effectiveness is accurately reflecting the wide-ranging 'menu' of what is potentially on offer.

A key conclusion from the CPN process was the importance of the wider context. TA in the health sector functions as part of the wider environment. As a result, it may be that general civil service reform is needed to make TA in the health sector more sustainable, as was the case in Ethiopia and Tanzania.

The notes highlighted the need to recognise that each country has different capability, institutions, cultures and incentive structures operating in the health sector and the wider public service. Each of these will have implications for how TA operates. Within the eight key findings identified from the countries visited, we attempt to draw out some of these differences to better understand the underlying reasons.

2. The demand and supply analytical framework

The conceptual framework used for the country notes was structured around the demand and supply of TA. Demand and supply conditions and drivers arising from incentives in donor agencies and recipient countries may be either explicit or implicit but can be viewed as ultimately determining how support is provided. These conditions may positively or negatively affect the provision of TA. Figure 1 presents a highly simplified presentation of how demand and supply could interact and how this may introduce constraints that prevent supply responding to the demand.

While this demand and supply framework was useful for guiding the country analyses, all country visits found that many important issues fall at the interface between demand and supply and depend upon their interaction. This indicates the complexity of the issues and how in reality it is much more nuanced: demand is often not clearly articulated and it continues to change and evolve; supply can be rigid and restrictive and also evolves and changes over time.

Figure 1: Framing the provision of TA: demand and supply and its interaction

1. **DEMAND**

Recipient country articulation and diagnosis of TA needs in a framework outlining key principles by which it is provided:

- Is there a clear understanding of the problem and the gaps?
- Is there an appreciation of how recipients want the TA to be provided?

Demand characteristics:

- Domestic commitment and capacity to absorb the TA
- Clear reform objectives articulated

2. **SUPPLY**

Supply characteristics that respond to the demand that is articulated including:

- Supply of TA responding to needs in terms of the mix of modalities, TA roles and functions
- A medium-term timeframe, prioritized, sequenced, timetabled; or a more flexible approach where appropriate
- Communications and follow up to ensure mutual understanding
- M&E processes and feedback loops to allow lesson learning and adjustment

3. **DEMAND & SUPPLY INTERACTION, CONSTRAINTS**

Supply constraints:

- Pressure to spend
- Risk aversion
- Procurement practices

Demand constraints:

- Reluctance to say no
- Staff incentives
- Lack of value for money

Interaction of demand and supply:

- Have principles/ 'rules of the game' been agreed, in partnership agreements, etc.?
- Is the TA well aligned with the 'demand' objectives?
- Have partners helped to articulate demand for advice or build capacity to work with TA?
- Is the TA built around sound relationships with authorities at local level?

3. Findings

Overall TA issues *beyond the sector*

1. **There is frequently an inadequate level of understanding and agreement between donors and government over what is considered 'technical assistance', and what is potentially on offer.**

   In several country examples there was a lack of consensus between donors and government over what is meant by the term 'technical assistance'. For example, the Uganda country note suggested four broad different types of TA that are commonly used in the country, but recognised that there has not yet been a coherent attempt to map and categorise the multiple interventions. In Ethiopia, national staff hired to fill line positions in regional and local health delivery boards were recruited and deployed as 'TA' even if their role is to gap-fill for insufficient national capacity. Indeed, attempts to map the full range of TA activities across the health sector in Ethiopia had run into difficulties in part because of definitional issues.

   In some instances, the TA that is on offer is not what governments would ideally like, and there is a lack of awareness of what might potentially be provided by donors. In Sierra Leone, donors were reluctant to provide hardware and infrastructure (e.g. internet connections, vehicles, offices) that government saw as a priority; and often provided a particular type of TA (e.g. internationally recruited resident advisers) that government did not always see as most beneficial. There was little sense in Sierra Leone that government and donors had been through a joint process to define and map existing TA approaches,

and/or to explore exhaustively what kind of assistance donors would be prepared to provide and under what circumstances. In Solomon Islands, the small size of the country and the comparatively large influence of donors (including multilateral partners) increased the degree to which the different attitudes of individual agencies can have an impact on the range of TA options that donors are prepared to offer. Similarly, in Uganda, some donors were only prepared to provide direct or in-kind TA, while others financed project or basket accounts for government to spend more flexibly on TA. The available modalities were not always clear to governments.

The broader government-donor relationship affects the operation of TA on the ground. In both Uganda and Tanzania, for example, deterioration in the general level of trust between donors and government had affected the nature of TA offered by donors. In Uganda, a switch by some donors from general budget support to project-based approaches shifted the emphasis of TA from capacity building for sustainable improvement in national systems towards supporting the management and delivery of individual donor projects. In Tanzania a deteriorating government-donor relationship combined with a resistance to external input has reduced the willingness of government to accept international TA in general.

- Do national institutions have a good understanding of the 'menu' of TA options that may be available to them? If not why not?

- Can donors do more to set out the full range of options that might be available to governments? How might this be done?

- How might the broader donor-government relationship affect, limit and/or support certain types of TA provision?

2. While capacity substitution / gap-filling remains a necessity in some situations, the potential methods to mitigate negative impacts are not receiving much attention.

The drivers of gap-filling behaviour differ by context. In the example of Solomon Islands, both government and donors recognised that structural constraints (notably its small size and remoteness) limited the functions which can be sustained in the country. As a result, there may be specific instances where long term gap-filling and capacity substitution does not risk diminishing national capacity. In Uganda, concerns in some sectors about the quality and efficiency of delivery led donors to provide TA simply to ensure effective implementation of their projects – a form of gap-filling - compared to some sectors that attempted more deliberately to build capacity in government systems. In a similar way in Sierra Leone, the importance some donors placed on delivery of certain policy objectives meant they were sometimes prepared to pay contract staff to work in government systems to simply get the work done, despite the problems of national institutions managing two different types of personnel within the same organisation.

Long-term capacity substitution and gap-filling are widely recognised to have some negative impacts. In Sierra Leone, Tanzania and Uganda the presence of highly paid – often international – TA staff working alongside regular civil servants was frequently resented, although in Uganda the local staff are more resented than internationals, as national staff are perceived to be less credible by some. The use of salary top-ups and augmented wages

for national TA staff in key roles also led in some instances to the development of 'parallel workforces' within the same institution, with some TA staff more accountable to donors than to government. Where this happened frequently in Uganda, particularly in the Ministry of Health, there was a perception that, while individually, capacity gaps were filled, the combined effect undermined local capacity overall and created distortions in salary structures and work incentives. In some cases in Sierra Leone and Uganda, this kind of gap-filling approach was justified as being temporary in nature, with some attempts to secure official commitments in advance to take the TA staff onto the public payroll at a certain point in the future. However, while absorbing higher paid TA staff onto the public payroll may resolve some accountability issues, it does not necessarily solve issues of resentment as a result of differential remuneration in the absence of comprehensive public sector reform.

For some categories of TA, there is no real intention or expectation that gap filling will ever evolve into capacity building. For example, TA can be used to expand the existing workforce in the face of severe staff shortages by hiring national staff into (higher paid) line positions, such as in Ethiopia. In all the countries visited, TA is often hired solely to manage the back-office administration of a donor-funded project, such as project implementation or management units. TA can also be hired for specific technical tasks, such as the installation of new computer systems, which require skills that would not normally be expected to remain permanently on the payroll. TA can also be used to monitor government activity on behalf of donors to ensure correct use of funds and equipment. For example, in Sierra Leone TA has been funded to oversee drugs distribution specifically to reduce leakage, and in Uganda TA was provided to perform project delivery functions in management, audit or accounting roles, but without a clear plan as to how it integrated into government after the project ended. Projects often create new structures so that when a project ends it can be difficult for government to continue that role because the position does not exist in the structure of the unit and is therefore also not funded.

Despite these challenges, several examples were given of successful episodes of TA that delivered capacity development rather than just gap-filling, although in very different contexts. In Sierra Leone TA that delivered 'hard' technical capacity development for professional staff was seen as more successful than TA aimed at systemic management and institutional change. In Tanzania, the long-term embedded nature of advisers in the Aid Coordination Department in the Ministry of Finance had allowed for the movement from capacity substitution towards more sustainable improvements over time. In Uganda and Sierra Leone, donor augmentation of the salaries of selected staff undertaking key functions allowed for some institutional capacity development to occur 'organically' through long-term retention and motivation of skilled staff working for year after year in line positions. Although there can often be negative impacts of salary top-ups, such as resentment being created and the differentials not being sustainable, in these two cases the salary augmentation had a positive impact on productivity. An emerging lesson from the country studies was the need to consider long-term engagement in relationship building if gap-filling is to transition successfully into genuine capacity building.

In all examples of successful capacity building TA two key elements were noted: high-level leadership and TA personnel with an appropriate approach. The leadership of high-level reform champions who have a direct interest in a successful outcome was crucial. In Sierra Leone, for example, TA in the health sector was particularly effective during the Presidential

focus on delivery of the Free Healthcare Initiative. In Uganda, TA provision in the water sector was considered successful because of the high level of engagement and ownership by government. In Tanzania Presidential leadership, strengthened by chairing an international committee, was key in ensuring that TA was useful in building capacity to improve monitoring of reproductive, maternal, and neonatal health outcomes. Furthermore, the attitude and working style of the TA was also highlighted as being critical to successful capacity building. In Sierra Leone, Uganda and Tanzania examples were given of capacity building faltering as a result of technically well-qualified TA providers failing to build good working relationships of trust and mutual respect with local counterparts. Ensuring that the right kind of individual, who has the appropriate attitude and who is technically and politically astute, is recruited into TA roles aimed at capacity building emerged as a key issue from the country notes and this is discussed further in key finding 7.

- Is gap-filling TA something that should always be considered temporary, or are there circumstances in which permanent gap-filling is inevitable and useful?
- Could gap-filling be structured in such a way to more easily lead to more sustainable forms of development? How can government and donors recognise where this might be most likely to happen? Could project implementation or management units be accompanied by plans for their full integration?

Technical assistance at a *sector* level

3. Health sector plans and strategies can help the articulation of demand for TA and the coordination of TA supply. However, a strong sector plan does not necessarily mean that TA needs are well understood or addressed.

A fully demand-led system is not always desirable or feasible although it remains important to continue to look for ways to build government capacity to better articulate TA needs. In almost all of the countries visited the leadership that government was able to apply in the recruitment process was constrained as government capacity was stretched. Donors in Solomon Islands, most of which have limited technical capacity in country, found dialogue was needed to clarify requests and match those to what might be available. A gap between demand and supply was observed in Sierra Leone. Whilst government felt that the TA supplied had scope to be much more responsive to needs, donors' views were divided as to government's ability to plan and lead on TA design and selection. In some cases this resulted in limited involvement and hence lack of ownership by government in decisions regarding TA. The countries involved in the study differed in the nature of their demand. For instance there were open attitudes to TA in Sierra Leone, Uganda, Solomon Islands and Ethiopia whereas there was a reluctance to integrate external TA in Tanzania.

It is possible to build the quality of demand through applying good analytics and facilitating an informed dialogue about what TA is needed for, how it should be deployed and by whom. The experience of health sector partners in Solomon Islands was that developing good quality demand for TA was facilitated by more clearly identifying the specific needs to be addressed, through discussion and analysis of constraints, against which options for supply can be developed. In Uganda some donors felt that the articulation of demand can be improved where there is a strategy developed that builds a common understanding of TA needs, preferably from evidence such as a capacity needs assessment.

This was seen where sector working groups worked collaboratively (e.g. water sector) and were able to use studies and dialogue to provide some diagnostics on sector performance and suggest associated actions. In this way, sector plans can also enable the tracking of progress. As demand improves, all partners are likely to be better able to determine what changes are needed to improve supply.

Existing sector coordination mechanisms can help governments and partners to develop a joint understanding of TA needs. There was some evidence that sector plans and strategies can help government and partners to build common view about what success looks like and share an understanding of the longer-term contribution that TA might make to sector performance. This facilitates the articulation of demand for TA, the coordination of TA supply and the ability of donors to meet the demands of governments for longer-term sustainable capacity development. For example, the process of developing sector strategies can facilitate joint assessment and diagnosis, such as the annual sector reviews undertaken jointly by government and development partners in Uganda. The supporting structures also tend to facilitate coordination. In Solomon Islands for example, implementation was more successful where all parties were committed to improving the value added of TA through dialogue. In combination with analyses of system performance, partners were able to align support, including TA, with government priorities and make use of government systems. The policy dialogue on sector resourcing in the donor coordination group was found to directly support the strategy, facilitate coordination and match demand and supply through dialogue. In another example from Solomon Islands, health sector PFM capacity was developed through an initial financial management audit leading to a roadmap, under which development partners were able to coordinate TA inputs. It was, however, noted in Tanzania how the deterioration in the relationship between government and donors had resulted in many of these coordination benefits not being fully realised. This indicates that even when structures are in place their effectiveness depends on how well stakeholders work together in practice.

In contrast, the lack of a plan for the capacity of the sector as a whole can make it more difficult for government and donors to plan longer-term sector-wide capacity development initiatives, leaving most TA to be defined at the individual project level. The lack of such a plan in the health sector in Uganda was lamented by some donors as it would have provided an underpinning justification for sector capacity initiatives compared to individual project objectives, the absence of which was seen as a barrier to mobilising effective TA support for capacity development. In Sierra Leone, the lack of a widely supported health sector plan made it more difficult to determine jointly where the TA gaps were. Some donors felt that in the absence of such a plan it was difficult to coordinate and manage TA. **The selection of the type of TA was often not transparent and based on the availability of resources, which are determined much further upstream in the donors' planning.** Therefore, by association, the recruitment, supervising, mentoring and management of the specific TA and the extent of associated flexibility is determined upstream. This was found to be the case in Solomon Islands and in Sierra Leone, in which some donors acknowledged that their TA response was not always flexible enough to adapt to changing circumstances. The procedures for identifying, procuring and managing the TA were felt to be important features which should be worked out jointly and transparently.

- How might a joint government-donor 'vision' or 'plan' for the sector as a whole improve effectiveness of TA?

- How can governments at different levels of capability formulate their demand for TA? Why is capacity building to help governments articulate their demand for TA often not a priority?
- How useful are cross-sector frameworks in providing a joint understanding between government and donors on what types of TA can be put in place?

4. Experience with TA policies, frameworks, tools, guidelines and mapping exercises is mixed.

Where TA policies and plans do exist there may be some further mechanisms needed to be able to implement them. Attempts to specify mechanisms more clearly were suggested in the Solomon Islands note, where, for example, producing a sector plan and concomitantly considering TA needs for its implementation would appear to be useful. Here a sector plan could describe the overall expectations of TA and demand-supply mechanisms, then an HR plan might define which positions are filled and the type of TA, while operational plans could define expected inputs and outputs. The Solomon Islands government and partners developed a simple list of all TA being provided that is shared amongst government and donors to reduce the chances of duplication and overlap. This is also being used as a tracking tool. This was also however to be attempted in Ethiopia but did not get very far largely because agreement could not be reached on the definition of TA, and information was highly dispersed. The draft Solomon Islands Technical Cooperation Framework for the health sector was expected to be a useful tool. It sets out ground rules on mechanisms for technical cooperation to improve effectiveness, to share knowledge about needs and supply options at the modality level, and allowing for adjustment in the supply or nature of TA in response to feedback on its implementation. Here annexes on TA and protocols are provided for visiting missions.

In practice the principles identified in the tools are not always followed and implementation did not always take place. In Sierra Leone and Uganda, it remains a challenge to ensure that the plans, protocols and guidelines are actually implemented and interpreted in line with sector priorities. In Uganda the water sector capacity building programme, which included TA, aimed to address institutional capacity constraints and several studies were undertaken in the health sector to map and understand the nature of TA supply and recommended principles for effective TA use. In practice, however, sometimes urgent gap-filling needs arose and sometimes donors were interested only in delivery of a specific project, which limited the scope of TA provided. In Ethiopia, it was felt that the systematic formulation of TA requests could help to build up incrementally a more complete picture of what is currently provided and what is required, rather than developing a larger master plan, or other tool. This may also help to build in individual flexibility more iteratively to adapt to different organisational contexts.

In most of the countries explored, there was some evidence that the large volume of TA, while individually useful, can undermine local capacity as it diverts management resources. This can happen due to the heavy management burden, as found in Tanzania, and also where the TA ends up substituting for national capacity. While positive evidence of coordination was found in Tanzania, where several 'Technical Working Groups' within the health sector brought together donors and government there were rarely discussions about how TA could be coordinated or streamlined amongst donors. In Uganda, the health sector

strategy highlighted systems and policy areas that required support, several of which have benefited from TA. Nonetheless, the combination of so much TA across so many projects was cited by some as weakening the overall sector capacity.

In practice TA was often based on individual donor projects and there was no overall capacity development plan for the sector. Ideally, the whole suite of TA options would be considered in the dialogue, and evolve and improve over time. Uganda's Health Compact outlined joint partnership principles for planning and implementing effective TA, among other types of support. Similarly, in Tanzania, there were aspirations to favour national TA, articulated in the Joint Assistance Strategy (in the absence of a specific TA policy), but in practice TA deployment tended to be determined by the sector and was somewhat *ad hoc,* depending on donor and government actors involved. Yet, in Solomon Islands, government appeared to be planning to develop a more strategic capacity development plan through the Ministry of Public Service, which was hoped to provide a framework for mobilizing a range of TA options. In Sierra Leone, there was a cross-government aid strategy, however it was not used in practice.

- How might health ministries and donors work together to identify which sector-wide TA tools are needed and to develop these?
- What are the consequences and possible actions if the TA plan cannot be effectively implemented?

Operational deployment of TA

5. Working with counterparts is conventionally considered 'good TA practice', and widely used but often does not work as intended or stated.

Counterparts appeared to work well when there are common goals, the TA provider works in an appropriate style and when there is support from the leadership.

The country explorations found that the way in which counterparts and supporting systems are used is important for the extent to which the TA can influence the sustainable development of capacity. As discussed in key finding 2, in Tanzania an increase in capacity was sustained by two committed government counterparts, two effective ODI Fellows and a manager who made supportive organisational changes that institutionalised the increased capacity. Similarly in Uganda there was investment (supported by donors) in local graduate economists who were able to absorb the new ways of working introduced by the TA. This strengthened local capacity.

Counterparts appear not to work so well when they are not recognised or identified, are too busy to engage, or where there is resentment about pay differentials. TA working in departments with weak capacity, absenteeism and low motivation are less likely to be able to strengthen local capacity and often work in isolation. In Tanzania, a long term adviser to the health sector was not able to establish a close working relationship with a counterpart, which resulted in a strong gap filling focus and a risk that any potential development of skills within the department was not possible. In Uganda it was found that where there is not such a huge gap between the TA and local counterparts in terms of skill and wages a greater sense of team working was possible.

The role of management and leadership in mutually reinforcing individual and organisational counterparts and change is important to embed increased capacity. This was highlighted both in the Tanzania case described above and also in Sierra Leone. TA was most clearly effective when applied to policy initiatives in the health sector that had the explicit and public backing of the President. In Sierra Leone the senior management team was highly responsive to the Presidential directive. These cases highlight how individual counterparts and the supporting systems may work together, particularly when driven or supported by senior leadership.

The country notes suggest that clarifying who are the primary counterparts and what supporting systems are needed are useful prerequisites as these features are likely to facilitate the TA to be more effective.

- How can the appropriate balance between *individuals* and supporting *systems and processes* be determined and ensured?
- What can donors and government do to match the most appropriate types of individual TA with counterparts they can most effectively work with?
- Would some form of prerequisite or required demonstration of commitment from counterpart institutions or individuals be useful before the TA is deployed?

6. **Using national systems, in line with the commitments made in the Paris Declaration, can improve government ownership of TA interventions; but sometimes donor systems are preferred.**

Procuring TA through government systems was seen as likely to improve government ownership, but donors often resist this approach. The Sierra Leone aid policy is clear that donors should use government systems as the first best option for procuring and managing TA. However, in practice this is not generally followed and many donors do not have sufficient confidence in government's ability to undertake a rigorous procurement process. Similarly in Uganda, some donors are not able to provide funding directly to government to purchase TA, but instead offer off-budget and/or separately managed TA that is less flexible.

In other circumstances, however, donor systems for procuring TA were preferred for reasons of speed and efficiency. In Tanzania, donor procurement processes were sometimes favoured by government as they could be quicker than national systems. In addition, in practice informal contacts were often used to identify the best TA provider, and donor systems often allowed flexibility for a particular candidate to be selected. Similarly in Sierra Leone, sometimes government would actively seek a donor lead on TA procurement, knowing that the relevant advisers would likely appear faster and their selection would be free from political interference.

There can be scope for developing protocols to involve government more actively in delivery of TA, even if donors prefer to use their own systems. In Solomon Islands, national ownership of TA was promoted by having government participate in the process of developing the Terms of Reference (ToRs) for the TA and briefing the relevant individuals, even if procurement was done by donors. TA was sometimes integrated into government systems by ensuring it is 'on plan', and recorded in the budget, even if the funds are handled by donors. In Sierra Leone, during provision of TA for the flagship free healthcare initiative,

there emerged a system of 'no objection' from government for selection of TA. In contrast, some donors in Uganda were able to include checks in their processes, requiring donor 'no objections' to government decisions at key stages. These both present examples of where procedures can be adjusted in response to different national capacity.

- In procuring TA, how might use of government systems – and therefore national ownership – be encouraged?
- If donors cannot pass funds to government, what other parts of national procurement systems can be used?
- Are there times when it might be appropriate for donor procurement systems to be used instead of national systems?

7. The individual characteristics of the TA provider and the building of trust are important for the TA to be effective

The individual characteristics of the TA recruited were found to be important in all countries. All country experiences provided examples – sometimes several – of technically well-qualified TA personnel who failed to build a relationship of trust and mutual respect with national staff. As a result of a poor relationship, little long-term capacity development could take place. While sometimes this was due to the challenging institutional context in which the TA was working, in others it was a result of the professional style and ways of working of the individual TA personnel involved. For example, in Sierra Leone, government staff in one institution complained that they sometimes felt 'bossed around' or 'looked down on' by predominantly international TA who were supposed to be helping them develop their capacity.

Structural barriers to building effective working relationships may exist, such as significant salary differentials between international TA and national staff. In Uganda and Tanzania, there were examples of the negative effects on working relationships that the presence of long-term highly paid international TA can have when working alongside much lower paid national staff. High turnover of international TA compared to national staff was also seen as a barrier to effective delivery of capacity development in some circumstances. Accountability to donors rather than government can present another structural barrier to building trust, discussed in key finding 8. This limited the ability of the TA to be seen as 'part of the team'.

Practical examples of how TA can build good relationships were identified. In Uganda and Tanzania, it was noted that 'quick wins' were often vital to build trust between government and TA personnel. Other instances found that it was important for TA to get 'stuck in' to the work of the relevant institution in order to demonstrate usefulness early on. There were examples across the cases that where the TA is part of a pre-existing team, trust can sometimes be built more effectively. In Sierra Leone, there were examples of where long-term national TA had stayed in institutions for many years and as a result of length of service and accumulated expertise had developed good relationships with national staff. In Sierra Leone, TAs who were clearly technical experts – for example, in IT systems or medical procedures – appeared to find less resistance in delivering their interventions, mostly because their skills were so specialised.

- How important is personal style and 'soft' communication skills for making TA successful? Are there circumstances where it doesn't matter?
- How can recruitment and deployment of TA better take into account the 'soft' side of capacity building? How can government state its preference for who it can (and can't) work with?
- What practical lessons can TA personnel take to their work to maximise their chances of being accepted and listened to?

8. **Efforts to strengthen accountability of TA to government as well as to the donor community are important; but dual accountability is often problematic.**

Direct reporting to and oversight by government, rather than donors, combined with flexibility in determining outputs is most effective in building trust. In instances of long-term capacity building there are good examples within the country experiences of a 'hands off' model of monitoring TA that specifically allows government and TA to 'find its own way' to better performance. The successful examples in Tanzania, highlighted above, suggest that TA providers who had delivered sustainable change tended to be those who reported directly to senior civil servants, had operational freedom to determine their own objectives jointly with government and built trust over several years. Similarly, gap-filling TA in public institutions provided as a result of a chronic shortage of skilled personnel – for example, recruitment of staff into the Ministry of Health in Ethiopia – may be intended to be fully accountable to national authorities and have little relationship to the donor providing the funding. Conversely in Sierra Leone, some government staff gave examples where certain long-term TA working in their organisation funded by donors were essentially reporting back to that donor, rather than answering to government. This limited the ability of the TA to build effective relationships with government. The 2009 Pacific Island Forum Compact on Aid Effectiveness included provision for peer review of national development planning, which could form a possible model for reviewing TA arrangements. The draft Solomon Islands Aid Coordination Strategy aimed to improve the monitoring of aid, including TA, and to clarify its relevance, added value and transactions costs in order to get a more strategic oversight of investments at the sector level.

In Uganda there was an example of skilled TA being provided with a flexible remit and a distant accountability relationship to donors, due to being hired as line employees in a central government unit. This allowed for national authorities to find their own way of navigating government systems so as to deliver better capability, in this case in monitoring government outputs. Some donors are prepared to take what they perceive as a risk in allowing government and TA to take the lead in determining what the content of the TA work should be and what are the associated outputs, as well as undertaking day-to-day management. Other donor systems are unable or unwilling to offer this kind of flexibility and freedom and require explicit specification of outputs upfront and much closer oversight of performance.

A 'problem focus' provides a particular way of monitoring the progress of TA. Deployment of TA to solve a jointly recognised problem can allow donors and government to assess TA progress more clearly, with reference to how far the problem has been solved. For example, delivery of the 'Poverty Monitoring and Analysis Unit' in Uganda through TA aimed to

respond to a specific need identified by government (in this case, to promote evidence-based policy making); as a result, progress could be monitored against delivery. In Sierra Leone, establishment of the new decentralised service delivery systems that were heavily supported by TA provided another example of a clear high-level outcome against which progress could be assessed. In some circumstances, the clear end-point of what success looks like provides a sharp form of accountability. In other cases, particularly where capacity building is involved, a different vision of progress may be necessary. In ToRs developing capacity was usually not accompanied by specific outputs that could be monitored.

- What kind of monitoring is appropriate for what kind of TA intervention?
- How can TA oversight arrangements be structured so that government as well as donor has a role in overseeing and monitoring TA outputs?
- Is a 'problem-focused' approach to monitoring progress of TA suitable for many TA interventions, or only in specific circumstances? What sort of monitoring could effectively measure capacity increases?
- Is there a limit to how responsive TA can be to government needs if donors require upfront specification of expected results? What level of flexibility could be considered a minimum?

4. Conclusion

The key issues discussed above were organised under three levels of analysis: issues in TA that go beyond the health sector; how TA operates at the sector level; and challenges of operational deployment of TA.

The brief country analyses highlighted some similarities in terms of capacity and managerial/operational gaps, and how country-donor relations reflect common patterns in the politics of foreign aid with associated impacts on the provision and uptake of TA. For example, all the countries aspire to use TA to build capacity whereas in practice due to operational gaps, unavailability of staff to work with, lack of motivation, and so on, TA often ends up with a stronger gap filling focus. The recurring findings are that TA needs reform, that the knowledge base about how to improve both demand and supply is thin and that the guidelines and processes for managing the TA system are either insufficiently developed, or are most often are not implemented in practice, all of which point to prospects for positive change.

These findings are not country-specific failings, but rather they highlight opportunities for some reflection within and between governments, multilateral and bilateral agencies. There is scope to consider how recipient government and donor procedures can increase rather than limit the extent of flexibility in TA provision, and how supply can be better matched to demands.