Study exploring the evidence relating Health and Conflict interventions and outcomes

Commissioned by the UK Cross Government Group on Health and Conflict

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Key Terms

The following is drawn from the excellent studies by Jack Eldon, Catriona Waddington & Yasmin Hadi (Eldon et al, 2008) and Sarah Bailey, Sara Pavanello, Samir Elhawary & Sorcha O’Callaghan (Bailey et al, 2009).

**Statebuilding**
An endogenous process to enhance the capacity, institutions and legitimacy of the state driven by state–society relations (OECD, 2008).

**Resilient State**
A resilient state requires: organisational capacity; legitimacy; political processes to manage expectations (the compact between state and its citizens); and access to resources.

**Fragile states**
A fragile state is one which lacks some or all of the characteristics of a resilient state. It is useful to think of a continuum of fragility and to consider in which direction a particular country is going – is the situation improving or worsening?

**Health systems strengthening**
Health systems strengthening (HSS) is a sub-set of activities within the health sector - activities which build institutional capacity to manage resources, provide or regulate services, and ensure there is an acceptable interface between the health system and the population. HSS is essentially state-building at the sectoral level. Not all activities in the health sector contribute to state-building or indeed HSS.

**Early Recovery**
A multidimensional process of recovery that begins in humanitarian settings guided by development principles that seek to build on humanitarian programmes and catalyse sustainable development opportunities. Aims to generate self-sustaining, nationally-owned, resilient processes for post-crisis recovery. Encompasses
restoration of basic services, livelihoods, shelter, governance, security and rule of law, environmental and social dimensions and reintegration of displaced populations.

**Stabilisation**
Efforts to end conflict and associated social, economic and political upheaval. Includes a range of activities from military intervention and humanitarian assistance to governance and policing (Bensahel et al., 2009).

**Peacebuilding**
Activities by international or national actors to prevent violent conflict and institutionalise peace, understood as the absence of armed conflict and a modicum of participatory politics that can be sustained in the absence of an international peace operation (Call and Couzens, 2007).
Preface

In the post-Cold War World health has become firmly rooted in state foreign policies through initiatives such as the UK’s ‘Health is Global’ strategy. However, since 9/11 there has also been growing interest in the interactions between health sector interventions and state fragility. Whilst fragility clearly has a negative impact upon both health outcomes and the capacity of the state to respond to health issues generally, there has been a growing assumption amongst policy makers and practitioners alike that carefully formulated health programmes contribute both to social stability and more widely to a state and peace building agenda. The models of how health affects social change can be grouped within the following broad themes:

- Health interventions as an element of service delivery are thought to impact upon perceptions of the legitimacy of the state.
- Health interventions build social capital that encourage governments into greater levels of responsiveness – and contribute to enhanced legitimacy.
- Health interventions bridge the divide between belligerent communities and facilitate peace/ameliorate violence.
- Health interventions contribute to the protection of core institutions and people (a core component of UK stability logic) and consolidate stability.
- Health wins ‘hearts and minds’ for the military.

A particularly prevalent assumption appears to be that improvements in health service provision strengthen the capacity of fragile states to signal their increased willingness to respond accountably to the demands of their populations. This is viewed as having the potential to legitimise the state through creating or reinforcing a social contract that is inherently stabilising. The statebuilding assumptions are generally rooted in a belief that enhancements to the governance of the fragile state’s various health sector institutions have wider consequences for the consolidation of the state that extend beyond the institutions necessary for the direct delivery of health services; spilling over from the health sector into civil society whilst also stimulating the state to develop capacities in other areas from the raising of tax
revenue through to mechanisms for ensuring beneficiary accountabilities and reconciling or determining other service delivery priorities.

Particularly since the invasions of both Afghanistan and Iraq, the fragile state agenda has increasingly merged with aspects of western military counter insurgency doctrines. The so called ‘securitisation’ of assistance and the military provision of basic health care services are widely viewed, particularly within the US military, as key components in winning the ‘hearts and minds’ of beneficiary populations and delivering security benefits – usually defined in terms of increased access to intelligence and information that enhances the force’s own protection but is also frequently pitched in terms of precipitating broader attitudinal change amongst beneficiary populations.

Whilst donors have exponentially raised their expectations as to what health interventions may achieve, in the context of fragile and conflict states there remain significant concerns. Firstly, that harnessing health interventions to a broad array of stabilisation and state building objectives may diminish the effectiveness of the health programmes themselves and secondly a suspicion that the supposed wider benefits are rooted in too flimsy an evidential basis to justify this cost. Undoubtedly there is the potential for the stabilisation and counter insurgency agendas to change conventional health priorities through introducing political distortions and a logic of short termism into programming decisions. Similarly the association between health actors and the counter insurgency (COIN)/statebuilding agenda may limit access to beneficiaries and endanger health care staff – effectively making healthcare provision another dimension of the conflict.

Whilst the discourse on the impact of health care provision in fragile states has become increasingly complex, there remain significant misgivings over the empirical foundations of the debate. This research project reviews the available literature; identifying the key ‘superordinate’ goals (i.e. the higher order goals linked to statebuilding and stabilisation objectives) for health whilst assessing their underlying evidential foundations.
Summary and Findings

This paper:

- Explains the emergence of the health agenda as a factor in state stability (chapter One).
- Demonstrates how stabilisation drew from and merged with the fragile states, statebuilding, peacebuilding, counter insurgency and early recovery literatures (Chapter Two).
- Explains how the literature captures the mechanisms through which health interventions are thought to contribute to ‘stability’ in conflict and post conflict environments (Chapter Three).
- Evaluates the quality of the evidence base for each of the major theories of change and the issue of agency (Chapter Four).
- Draws general conclusions and recommendations.

Chapter One
Conflict undermines health indicators through three principal mechanisms:

- Causing increases in direct morbidity (including widespread disability and mental health problems) and mortality.
- Causing increases in indirect mortality and morbidity through the corrosion of health services – due to the destruction of health infrastructure, the flight of medical personnel, chronic insecurity reducing beneficiary access and the diversion of human and financial resources away from public health.
- Causing increases in indirect mortality and morbidity through the negative effects on a broader range of health determinants – particularly:
  - Environmental. Population displacement increases population vulnerability - worsening hygiene and sanitation, increasing over crowding and facilitating the spread of communicable diseases.
  - Economic. Increases poverty and food insecurity thereby reducing nutrition levels and increasing vulnerability to disease.
Chapter Two

- Health interventions have evolved from simply being concerned with addressing health outcomes to addressing societally destabilising factors and being a potential strategic instrument of states.
- Stabilisation’ is not a clearly defined concept and ‘stabilisation programmes’ are strongly context dependent.
- Stabilisation concepts tend to rely on external support for improvements in local governance, community voice and governmental accountability, service delivery and external support for state survival functions. They also tend to focus on supporting a political settlement or, where this is absent, on developing social capital which can lead to civil society engaging with and making demands upon government.

Chapter Three

Health interventions are hypothesized to have a stabilising impact by:

- Preventing conflict or reducing conflict levels through highlighting the costs of conflict.
- Peacemaking in conflict. Peacemaking relies on the belief that belligerents have a common interest in healthcare provision and this will be sufficient to overcome political or strategic obstacles to dialogue. Typically this enables negotiated access, often around programmes providing for the immunisation of children. This process is seen as being able to generate trust that is sufficient to enable broader negotiations that can ameliorate the effects of violence and lead to broader peace processes.
- Peacebuilding after conflict. The peacebuilding approach is based on the belief that where health provision improves this will have a positive impact on the legitimacy of governments. Arguably there are three components to this: the first is a general sense that public service provision enhances government performance legitimacy and perceptions of responsiveness thereby reducing societal propensity towards conflict; the second is that carefully targeted health interventions help to undercut grievances based on a group’s (ethnic, religious or tribal) belief that government service provision in inequitable and thirdly that health issues can be a vanguard of reintegration and demobilisation processes.
There is a degree of confusion as to how stabilisation relates to other policy discourses – particularly the UN’s early recovery concept and the securitisation of assistance. To some extent these may be competing discourses with early recovery seeking to maintain a closer connection to humanitarian principles than stabilisation appears to allow.

Whilst military involvement in the delivery of public services tends to be described in terms of the logic of ‘hearts and minds’ the drivers of military involvement in health issues are more complex and tend to include:

- International humanitarian law obligations.
- The ‘Hearts and Minds’ logic.
- Mirroring of (Potential) Enemy Forces or Strategic Competitors
- The interaction between spare military medical capacity and medical ethics.
- Differential clinical capabilities between ISAF and the Afghan health system resulting in patient transfer issues.
- Support to state performance legitimacy through Public Service Delivery.

Chapter Four

In terms of the evidence base for health having a role in preventing conflict or reducing levels of violence during conflict it is possible to conclude that:

- Epidemiological studies demonstrating the impact of conflict on a population clearly can influence international responses to conflict. However, evidence on their impact on civil society within conflict states has not been collected systematically.

In terms of the evidence base for health having a role in peacemaking (during conflict) the evidence is mixed.

- There is strong evidence in support of humanitarian cease fires based around health access leading to significant reductions in mortality and morbidity rates in several conflicts. However, these tend to be examples of ‘humanitarian space’ rather than broader peace processes and many appear to rely on the sense that health interventions are discrete and apolitical interventions.
The literature is unable to demonstrate that health based access agreements have been responsible for or are significant factors in initiating broader peace processes.

In terms of the evidence base for health having a role in peacebuilding after conflict the evidence is, once again mixed.

- The peer reviewed literature does not appear to provide systematic analyses of the extent to which health system strengthening contributes to broader processes of state building and peace consolidation.
- The evidence base is credible in theory but is generally anecdotal, shaped by author bias and has not been subject to systematic research. Similarly there is little clear evidence of the impact on governmental legitimacy of the interaction between health system strengthening, the generation of community ‘voice’ and government ‘accountability’. These are clearly priorities for further empirical research.
- There is no credible evidence that military health ‘hearts and minds’ interventions have a positive impact on beneficiary community attitudes. In part this is due to the lack of empirical research. There are significant concerns relating to the medical effectiveness of military medical civic action programmes (medcaps).
- Subcontracting primary health care provision through NGOs appears to have many advantages in terms of rapidly extending the scale and reach of health provision. However, the impact on government legitimacy is not well understood.
Findings

The overall findings on the quality of evidence available were as follows:

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<td>Health outcomes</td>
<td>Evidence for improvements or decline in health outcomes generally strong. Outputs are easily defined and generally less abstract than in other areas. Monitoring processes tend to exist and are widely understood and accepted.</td>
</tr>
<tr>
<td>Stabilisation outcomes</td>
<td>Generally weak. Outputs and outcomes generally very difficult to measure due to the conflict environment, political context and abstract nature of issues such as legitimacy, voice, government responsiveness and social cohesion. Diversion of resources from monitoring to delivery weakens collection of data.</td>
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<tr>
<td>COIN outcomes</td>
<td>Generally very weak. No culture of critical evaluation and few systems in place. Operational analysis systems focus on kinetic measures and tactics rather than ‘influence’. Sensitivity of findings precludes review and publication.</td>
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<tr>
<td>Statebuilding outcomes</td>
<td>Generally strong in terms of institution building but much weaker in terms of analysis of capacity building, the role of civil society and functioning of accountability mechanisms.</td>
</tr>
<tr>
<td>Peacebuilding outcomes</td>
<td>Generally weak. Lack of systematic and rigorous monitoring and biases in reporting.</td>
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This paper was required to clarify and assess a number of specific issues. **Primary objectives** were to describe:

‘The association between introducing and/or strengthening health services in conflict environments and markers for stabilisation:’

In order to assess the association between strengthening health services and stabilisation it will be necessary to develop clear and measurable indicators of progress in the areas of health’s ‘superordinate goals’ (i.e. those related to higher order ‘stabilisation’ goals’) - yet rigorous stabilisation, health governance and civil
Society capacity indicators remain elusive and there is currently little investment by donors in objective and systematic M&E in these areas in the context of conflict states. Even if this investment is forthcoming there will remain significant challenges in developing these indicators and operationalising the data collection.

Nevertheless, in order to ameliorate the deterioration in health outcomes that are associated with conflict, ‘Health System Strengthening’ (HSS) should remain a priority. Even during periods of intense conflict where the Ministry of Health functions at severely reduced levels of effectiveness opportunities to support planning capacity should be sought. Subcontracting NGOs to rapidly scale up medical services, for example to deliver a defined basic package of health services (BPHS), is a valuable option but with a view to gradually transferring delivery functions to the state unless there is a compelling reason otherwise. Within the literature there is a strong consensus on the need for civil society to be involved in planning and monitoring performance in local health services and capacity building for accountability mechanisms should include communities and civil society and these should be planned for from the outset. Experience suggests that capacity building interventions at local, provincial and ministry level are necessary but the relative priorities are context dependent.

‘The nature of the relationship between health service delivery and stabilisation – positive, zero or negative’

In the absence of effective M&E it is not possible to draw empirically based conclusions. However, the absence of clear evidence demonstrating health intervention’s ability to deliver against the range of superordinate goals suggests that health should continue to be delivered for ‘health’s sake’ until the literature is able to draw sound findings that objectively evaluate the costs and benefits to health outcomes of associations with the superordinate goals.

‘Whether increases in health service delivery for wider stabilisation objectives, is having a positive or negative impact on health indicators?’
Sound empirical data within the literature is not available however the potential for stabilisation and peace building objectives to undermine HSS is widely reported on. There appears to be no evidence that the Provincial Reconstruction Team (PRT) in Helmand, both on the civilian and the military side, has distorted its health priorities to reflect the stabilisation agenda - instead it has been subject to other pressures related to transferring patients between NATO military and Afghan hospitals. The PRT was unable to provide evidence on trends in mortality and morbidity indicators at Provincial level. Similarly the BPHS implementing partner for Helmand (until recently the NGO ‘Ibn Sina’) purposefully distanced itself from ISAF. In the absence of this data it is not possible to draw reliable empirically based conclusions.

**Secondary objectives were to** establish how health services provided by government, multilaterals and bilaterals, and NGO programmes including faith-based organisations in a stabilisation context, can affect the perception of the government legitimacy amongst indigenous communities, looking specifically at:

‘Whether the delivery of government or government funded programmes improved community perceptions of the legitimacy of the government?’

Their is no data that is able to demonstrate empirically that government or government funded health programmes are able to improve community perceptions of the legitimacy of the government. The Afghan Basic Package of Health Services for example does not monitor this type of data. However, the Partnerships for Transforming Health Systems (PATHS) in Nigeria and the Reproductive and Child Health Care Programme Plan in Sierra Leone (anecdotally) appear to have had some impact on government legitimacy and this appears to be supported by Afrobarometer data.

‘If not, what do communities feel such programmes do, and does this impact on their view of state legitimacy? Is this dependent on the security situation and therefore does it change over time?’
The literature does not provide a systematic evaluation of this and there is very little literature drawn from beneficiary communities. More needs to be done to capture the voices of the beneficiaries and to develop models of how this contributes to building state legitimacy.

‘Whether the failure to sustain health services with a resultant increase in mortality and morbidity has an impact on the community perception of government legitimacy and the stabilisation programme?’

The literature does not provide a systematic evaluation of this although governmental failures to respond to severe health challenges brought about by natural disasters have obviously been politically destabilising – e.g. poor governmental responses to earthquakes in Morocco in 2004 and Pakistan in 2005.
Recommendations

The key recommendations from this study are:

➢ Develop stabilisation indicators (proxy and direct) and monitoring processes that capture evidence of progress towards the ‘super ordinate’ goals of health interventions. Ideally this should be piloted through the delivery of a Basic Package of Health Services (BPHS) of the type found in Afghanistan and seek to capture measures of citizen voice and government accountability and their interaction.

➢ Commission comparative empirical research into the dynamics of governmental legitimacy formation in conflict and post conflict environments and the ‘entry points’ for influencing this. Indicative research questions to include:
  o What factors enable citizen voice to be translated into more responsive service provision? How scalable is this process?
  o Is there an onward linkage from satisfaction with service delivery to satisfaction with government?
    ▪ If quality matters, which aspects of users’ experiences with service providers are decisive?
    ▪ For users, which aspects of service delivery matter more: quantity or quality/government, military or NGO delivery?
    ▪ What are the main determinants of service satisfaction?
    ▪ How satisfied are beneficiary communities with government performance in the health sector?
    ▪ How important are primary health care services among the development priorities of beneficiary communities?

➢ Ensure an objective and ongoing evaluation process for military ‘medcaps’ – focusing on health outcomes and the impact of medcap activities on perceptions of government and military providers. This should lead to recommendations on training and predeployment preparation for medical commanders.
Develop a cross departmentally sponsored policy note that defines HMG's approach to the role of health interventions in conflict and fragile state environments. This should be informed by a dialogue between the military medical services, the Stabilisation Unit and the UK humanitarian community, that enables a consensus to be formed on what issues around humanitarian space and means for HSS interventions in situations of intrastate armed conflict where the UK is acting in support of the host government. This should include, for example, guidance on defining the role of the military in supporting local health infrastructure in order to ameliorate difficulties caused by civilian medical transfers between military hospitals and local health care facilities, and on military medical services training to address the moral and practical issues of transferring civilians between military and host nation facilities.
Methodology

Study Objectives

Primary objectives:
To clarify and assess:

- The association between introducing and/or strengthening health services in conflict environments and markers for stabilisation;
- The nature of the relationship between health service delivery and stabilisation – positive, zero or negative; and
- Whether increases in health service delivery for wider stabilisation objectives, is having a positive or negative impact on health indicators?

Secondary objectives:
The review will also establish how health services provided by government, multilaterals and bilaterals, and NGO programmes including faith-based organisations in a stabilisation context, can affect the perception of the government legitimacy amongst indigenous communities, looking specifically at:

- Whether the delivery of government or government funded programmes improved community perception in the legitimacy of the government?
- If not, what do communities feel such programmes do, and does this impact on their view of state legitimacy? Is this dependent on the security situation and therefore does it change over time?
- Whether the failure to secure and sustain health services with a resultant increase in mortality and morbidity has an impact on the community perception of government legitimacy and the stabilisation programme?

Overview of Method:  The method involved a review of the academic, grey and donor evaluation literatures and key informant interviews relating to the 'stabilisation'
impact of health interventions\footnote{‘Intervention’ is used in its broad sense to denote the delivery of all types of externally generated programmes including vertical health programmes and health system strengthening.} on fragile and conflict state environments. The evaluation literature related to the impact of health interventions on a range of stabilisation goals. In addition the lead researcher conducted 30 sample interviews with individuals drawn from key practitioner and analyst communities. This process sought evidence to:

- Explain the emergence of the health agenda as a factor in state stability.
- Demonstrate how stabilisation drew from and merged with the fragile states, statebuilding, peacebuilding, counter insurgency and early recovery literatures.
- Explain how the literature captures the mechanisms through which health interventions are thought to contribute to ‘stability’ in conflict and post conflict environments.
- Evaluate the quality of the evidence base for each of the major theories of change and the issue of agency.

**Literature Selection:** The literature review was conducted on a wide selection of published academic and grey literature as well as formal donor evaluations. Papers were identified through academic and other databases including: Athens, Swetswise, BMJ, the Lancet, Google Scholar, DFID Health Resource Centre, Conflict and Health Journal, Global Health Governance Journal, WHO, Pubmed, CAB Abstracts, Eldis, ID21, World Bank and OECD-DAC. Key search words included health, equity, conflict, violence, low income countries, fragile states, stabilisation/stabilization, statebuilding & health, peacebuilding & health, counter insurgency & health, health & conflict. In addition literature was selected through: bibliographies drawn from existing literature reviews; core stabilisation, COIN, peacebuilding, peacekeeping and statebuilding literature drawn from current international organisation (IO) (OECD, World Bank, WHO, etc), UK and US military and donor (USAID and DFID) policy/doctrinal/lessons learned frameworks; Historical material drawn from the reconstruction programmes following World War II, the US Vietnam era CORDS programme and the British experience in Malaya. This literature was selected by 2 historians with expertise in these areas; Contemporary
evaluations of health care and stabilisation interventions relating to the three case studies and provided by USAID/DFID. This material comprised both formal evaluations of interventions and anecdotal/narrative based analyses. Evaluations also drew attention to the experiences of beneficiaries and overcome, to a degree, the shortcomings in a literature base that is predominantly ‘northern’ in origins.

**Interviewee Selection:** This project was intended primarily as a literature review however a small number of interviewees were chosen to support the identification of theories of change and to develop evidence of ‘superordinate changes’ (i.e. beyond immediate health outputs) brought about by health interventions.

**Team Organisation:** Stuart Gordon was team leader and principal author. Amanda Baker was responsible for the Sudan case study and research support to the core chapters. Alexia Duten was responsible for the DRC case study and Paul Garner has been instrumental in developing a research protocol and quality assuring drafts.
Chapter One: Investing in health in conflict environments: Evidence of Need?

Aim and Findings

Aim

This chapter explores the impact of conflict on health outcomes.

Findings

Conflict undermines health indicators through three principal mechanisms:

- Causing increases in direct morbidity (including widespread disability and mental health problems) and mortality.

- Causing increases in indirect mortality and morbidity through the corrosion of health services – due to the destruction of health infrastructure, the flight of medical personnel, chronic insecurity reducing beneficiary access and the diversion of human and financial resources away from public health.

- Causing increases in indirect mortality and morbidity through the negative effects on a broader range of health determinants – particularly:
  - Environmental. Population displacement increases population vulnerability - worsening hygiene, increasing over crowding and facilitating the spread of communicable diseases.
  - Economic. Increases poverty and food insecurity thereby reducing nutrition levels and increasing patient vulnerability.

Links between declining health outcomes and armed conflict

During the 20th Century more than 191 million people lost their lives due to armed conflicts (WHO, 2002). However, the suffering brought by war extends far beyond
the direct violence to civilians caused by ‘shells, bombs and bullets. War often leads to severe damage or destruction of health infrastructure, departure of health workers, breakdown of water and sanitation systems, food shortages, and erosion of the state’s ability to prevent and treat disease, even as vulnerability to disease increases from the stress of experiencing violence and displacement. As a result, dozens of population-based studies have shown significant increases in morbidity and mortality from infectious disease, childbirth, and other causes accompanying armed conflict that are not directly combat-related. Indeed, populations that have experienced armed conflict often have among the worst indicators of infant, child, and maternal mortality, as well as very high levels of psychological impairment, of any countries in the world. Because of the breakdowns in health services and infrastructure, declines in health and life expectancy can be expected to last, and can even increase, in the years after the conflict ends’ (Rubenstein 2009).

Whilst estimating the scale of conflict related deaths not caused by military activity (i.e. indirect deaths) is notoriously difficult, the literature demonstrates both a consensus that indirect morbidity and mortality figures both tend to exceed direct mortality (e.g. Coghlan et al.; 2006; Lacina & Gleditsch, 2005; Newbrander 2007; Waldman 2007) in conflict situations and increase compared with periods without conflict. For example World Bank comparisons between fragile and non fragile state contexts (World Bank 2007a & 2007b) demonstrate strong differences in health indicators between these two situations whilst other authors are able to demonstrate that even within the same state these statistics worsen during conflict (Guha Sapir & Van Panhuis 2002). In their study of Angola and Sudan Lacina & Gleditsch (Lacina & Gleditsch, 2005) detail how indirect mortality comprised between 89% and 98% (respectively) of the overall total of war related fatalities and in 10 African conflicts identified that it amounted to between 71 and 97% of the total deaths related to the conflict (Lacina and Gleditsch, 2005). In one of the most compelling studies Coghlan et al (2006) demonstrated that mortality rates in conflict areas within the Democratic Republic

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2 ‘Indirect’ or ‘excess’ mortality is a commonly used descriptor for measuring the impact of conflict on civilian populations. It captures the death rate resulting from a conflict but not directly due to violence that is related to combat. See Francesco Checchi and Les Roberts 2005.
of Congo (DRC) were between 2 and 3 times higher than in the more stable areas. Similarly Ghobarah et al (quoted in Kruk et al) suggested that between 1991 and 1997, 15 million 'disability-adjusted life years were lost in 1999 alone in 51 countries as a result of civil wars waged between 1991 and 1997. This is twice as high as the WHO’s estimate of direct war fatalities in the single year 1999 (Ghobarah et al., 2004). Clearly there are exceptions to this finding. The war in Bosnia Herzegovina, genocide in Rwanda, ethnic cleansing in Kosovo and the invasion of Iraq in 2003 (Burnham et al, 2006) led to more direct deaths as a result of violent action than indirect deaths.

Our understanding of the causes of this phenomenon is also beginning to improve with analysis suggesting that conflict has had an important impact on health indicators through corroding health services and impacting negatively on a broader range of health determinants.

*Impact on health services*
Conflict frequently has a dramatic impact on state capacities through the displacement of key staff and the destruction of health infrastructure (Macrae 1995) as well as causing the breakdown of state policy and financing mechanisms (Zwi et al 1999; Roberts et al, 2008). It may also divert political and elite attention and resources towards managing the conflict and investing in military and state survival functions rather than maintaining the health sector – a theme also picked up by Plumper and Neumayer (Plumper & Neumayer, 2006).

Health facilities and workers may also become targets for political reasons. Following independence from colonial rule in 1975 the socialist Mozambique Government rapidly expanded primary health care and education provision. Subsequently the South African backed RENAMO insurgency targeted health care facilities and schools in its efforts to undermine the government (Pavignani and Colombo 2001). Cliff & Noormahomed describe how rebels deliberately killed at least 21 health workers during the course of the Mozambique conflict and, by 1985, had destroyed over half the health care infrastructure (Cliff and Noormahomed, 1996). Summerfield reinforces this, pointing out that half of Mozambique’s ‘primary health care network (over 1000 health centres) was
looted and destroyed and landmines were placed in the vicinity of hospital facilities. In Nicaragua and Peru, health posts in war zones were sacked and subsequently ruined to prevent one or another faction from getting medical supplies or services of any kind. Incursions by guerrillas and military personnel resulted in the exodus of health workers, with subsequent deactivation or destruction of services, surgical facilities, maternity wards, etc. In El Salvador, mutilated bodies of health workers were exposed with the letters EM (Escuadron de la Muerte or Death Squad) carved in their flesh, as a brutal warning to hostile opponents’ (Summerfield, 1995). As part of the return to ‘year zero’ and its decimation of the Cambodian professional classes the Khmer Rouge murdered health workers whilst during the Bosnian war (1992-1995) Croat and Bosnian Serb militia frequently targeted Moslem doctors. In Timor Leste the withdrawing Indonesian military destroyed large elements of the health infrastructure. The World Bank reported in 2005 that three-quarters of East Timor’s pre war health infrastructure had been damaged since the conflict began in 1999 (World Bank, 2000). The targeting of health and aid workers generally for political reasons has also been recorded in a wide range of other conflicts: Chechnya, Iraq, Afghanistan, Pakistan, the Philippines, Croatia and Bosnia, Kashmir, etc (Stoddard et al, 2009; for more historical material see Physicians for Human Rights, 1993; Summerfield, 1995).

Even when not directly targeted by belligerents, conflict and state fragility can seriously undermine health service provision. For example, much of Iraq’s medical infrastructure (laboratories, clinics, etc) was looted, increasing the population’s vulnerability to both routine illness and the outbreaks of endemic diseases such as cholera (Dyer, 2003). Physicians for Human Rights record how in Chechnya, Kosovo and Liberia as much as 80% of the health infrastructure was looted or destroyed (Physicians for Human Rights, 2001 and 2009).

Vulnerability to disease vectors and the disruption of medical programmes
A rapidly expanding literature (Coninx, 2007; Tiwari et al, 2005; Amato, 2008; Nunn et al 2008) points to the way in which such conflicts disrupt disease control and health programs – largely through refocusing the energy of health workers
towards conflict related injuries, disrupting access to health services by the population and supply chains to health facilities, and forcing political elites to divert medical resources to other conflict related ends. The impact of conflict on tuberculosis (TB), a major source of morbidity and mortality in fragile states, provides a useful illustration. Armstrong’s (Armstrong, 2007) review of the literature leads him to argue that warfare leads to rapid increases in mortality and morbidity rates from preventable diseases such as Tuberculosis (TB), with between 14 and 15 civilians dying for every combatant that is killed in the fighting itself. These results were echoed by Barr and Menzies (Barr & Menzies, 1995) whose survey of displaced persons in El Salvador in 1994 led them to conclude that the higher mortality and morbidity rates could endure long after the conflict had formally concluded. Armstrong develops this theme and draws attention to the European experience after World War Two, describing how the Tuberculosis rate in Holland rose from only ‘154 per 100,000 in 1915, to 180 per 100,000 in 1916, while the TB mortality rate increased by 50% in Berlin from 1916 to 1917.’ (Gele & Bjune, 2010) Other studies have reinforced these findings – recording a quadrupling of annual Tuberculosis cases in Bosnia and Herzegovina since the beginning of the Yugoslav wars in 1991 (Barr & Menzies, 1994) and others drawing similar findings across a broader range of case studies (Toole et al,1993).

Armed conflicts appear to increase the impact of TB in complex ways – impoverishment making people more susceptible to the disease whilst the destruction and looting of health infrastructure and chronic insecurity combined to reduce opportunities for diagnosis and treatment. Gele & Bjune argue that escalating poverty and malnutrition increase the number of TB susceptible individuals but also deter infected and infectious patients from being diagnosed promptly and gaining treatment (see also Ponsar et al, 2009).

Conflict has a similar impact on the prevention and treatment of other diseases. Beyrer et al highlight how in Colombia insecurity has a dramatic impact on vector-control programs, with the Chagas disease program reaching less than 16% of the high risk population (Beyrer et al., 2007). Coghlan et al point to similar processes exacerbating child mortality rates during and after conflict. Their
study, following the cessation of formal hostilities in the DRC, found that between 2003 and 2004 under fives comprised more than 45% of the total deaths despite being less than 20% of the overall population. The study suggested that the high rates of child mortality resulted from the collapse of the health system limiting the treatment of common preventable and treatable diseases such as diarrheal diseases, malaria and pneumonia (Coghlan et al., 2006).

The literature consistently stresses the idea that prevention efforts are ‘likely to be more effective where the health system is functioning, benefiting from nearby clinics and health workers for the supply of needed commodities, supervision for community health workers, and availability of diagnosis and early treatment (Kruk et al, 2010). In part this explains the emphasis on the strengthening of health systems rather than vertical single issue programmes (see chapter 2 of this paper).

In terms of the way in which conflict creates vulnerabilities the peer reviewed literature overwhelmingly demonstrates a range of effects from the general increases in poverty levels exacerbating both vulnerability to disease and other health risks as well as reducing access to health facilities. Although there are very few studies that provide a quantitative analysis of the social determinants of IDP health (Porter et al, 2005; Chotai et al, 2007; Cardozo et al, 2000) the literature does suggest that these factors tend to impact more on IDP populations. For example in 2000, MSF recorded a pellagra outbreak in Angola that was twice that of the non displaced population in the same areas. Similarly Checchi et al conducted nearly 90 surveys across 13 Angolan districts over a 4 year period from 1998. By 2002, when the conflict ended, some 40% of the total population, nearly 4.7 million people had been displaced. Mortality figures were over 82% higher than in more peaceful parts of sub Saharan Africa (Checchi 2006 and Checchi & Roberts, 2005.)

However, these effects are not always uniform and in some cases IDPs may in fact have better access to health facilities than non displaced populations - due to the provision of healthcare by the international community ensuring better access
and higher quality facilities than local authorities (see for example Singh et all, 2005; Howard et al, 2008; Orach & De Brouwere, 2004; Van Damme et al, 1998).

Conflict also tends to have a significant impact on sexual and reproductive health (Busza & Lush, 1999; McGinn & Purdin, 2004; van Egmond et al, 2004) and the particular vulnerability of women to sexual predation in such contexts is extremely well documented (McGinn, 2000; UNHCR 1999; Watts & Zimmerman 2002; Coghlan et al, 2006; Jewkes et al, 2002, Steiner et al; 2009). The most striking feature of this literature is the prevalence of rape in warfare. Ward and Marsh (Ward & Marsh, 2006) argue that whilst the current data may ‘simply reflect greater international attention to the issue -- provoked in part by the media coverage of the sexual atrocities committed during the conflicts in the former Yugoslavia and Rwanda, and even more importantly by the decades of intensive awareness-raising by women’s activists around the world -- rather than a significant rise in absolute numbers of victims. A more likely explanation, however, is that the nature of warfare is changing, in ways that increasingly endanger women and girls.’

Joanna Macrae (Macrae, 2005) points to the increased risk of rape by military personnel, higher prevalence of prostitution (turned to by women in pursuit of cash incomes ‘in the absence of other productive activities) and the partial or complete ‘breakdown in health services and the subsequent reduction in opportunities for treating sexually transmitted diseases, all increase the vulnerability of conflict-affected populations to HIV infection.’ (see also Smallman-Raynor and Cliff, 1991; Bond and Vincent, 1990). The situation is seen as a consequence of a complex of factors leading to a ‘disturbance of cultural norms and family composition; women’s economic dependence on men; lack of police protection and lawlessness; limited options for legal redress; aggressive behaviour triggered by the psychological strains of refugee life and strong social pressure to maintain the status quo in the face of enemy attack; and travel to remote distribution points for food, water and fuel.’ (Bournemisza et al 2010). In contrast men tend to die more from the effects of direct violence (WHO, UNICEF, IRC 2005; Pedersen, 2002).
Whilst the peer reviewed literature points to the overwhelmingly negative impact of warfare on mortality and morbidity rates above and beyond those killed by the direct effects of warfare, it also suggests that the effects are not entirely uniform. For example, whilst warfare can increase the transmission of and vulnerability to HIV (with the movement of armies and militia, the breakdown of law and order, economic and familial disruption increasing vulnerability to rape) the same processes may also isolate communities, cutting down opportunities for migration and economic/social interaction (e.g. trucking routes, seasonal migration). (Spiegel et al 2007, Strand, Fernandes Dias, Bergstrom & Andersson 2007).

Findings

This literature review suggests that indirect deaths resulting from conflict situations increase dramatically due to the disruption of access to and the strength of health services in affected countries and through increasing vulnerability to disease vectors. Furthermore, whilst the literature suggests that indirect deaths from fevers, malaria, diarrhoea, respiratory infections, malnutrition and child birth exceed combat related deaths, other studies, such as Coghlan et al (Coghlan et al 2006 and Coghlan et al 2008) associated improvements in security with significant reductions in excess mortality figures.

In part this explains the necessity for more holistic approach to health system strengthening and the greater emphasis placed on 'stewardship' that characterises contemporary discourses on health interventions and approaches by donors. However, the emergence of the fragile state and stabilisation agendas has also been a major factor in expanding the objectives of health interventions. The impact of war on health systems is neatly captured in the following WHO chart:

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3 ‘Intervention’ is used in its broad sense to denote the delivery of all types of externally generated programmes including vertical health programmes and health system strengthening.
Chapter Two: The Rise of the Stabilisation and Fragile States Agendas

Aim and Findings

Aim

This chapter:

- Explains the emergence of the health agenda as a factor in state stability
- Demonstrates how stabilisation drew from and merged with the fragile states, statebuilding, peacebuilding, counter insurgency and early recovery literatures.
- Defines stabilisation and its dominant theories of change
- Explains how various stakeholders relate to stabilisation

Findings

- ‘Stabilisation’ is not a clearly defined concept and ‘stabilisation programmes’ are strongly context dependent.
- Stabilisation concepts rely on improvements in governance, community voice and governmental accountability, service delivery and limited external support for state survival functions.
- They also tend to focus on supporting a political settlement or, where this is absent, on developing social capital which can lead to civil society engaging with and making demands upon government.
- Health interventions have evolved from simply being concerned with addressing health outcomes to addressing societally destabilising factors and being a potential strategic instrument of states.

Health’s Emergence as a Strategic Tool

In the past decade the health literature has undergone two particular changes in terms of the perceived linkages between health issues and state ‘stability.’ The first is in defining poor mortality and morbidity rates as forces that are sufficient to destabilise states. The second is the increasing portrayal of health interventions as
factors that have the potential to serve as foreign policy instruments - particularly ones that have utility in stabilising fragile and conflict states.

Poor Health as Destabilising

In terms of the former, several diseases (principally HIV/AIDS, Malaria and TB) are no longer portrayed in purely medical terms. There is a powerful evidential body that portrays these diseases as serious risks to the economic performance of many less developed nations (Moodie and Taylor, 2000; Kassalow, 2001; Hotez, 2002) whilst some authors conclude that ‘some of these diseases may have wider implications for geopolitical stability or the probability that a nation will experience armed conflict’ (Feldbaum and Michaud, 2010).

HIV/AIDS in particular is portrayed as a powerful destabilising force. Over 40 million people are HIV positive and the majority of these will die from the disease or its complications (Dixon et al., 2002). The impact on states is frequently described in terms of its ability to ‘hollow out’ their economic, social and security infrastructures with perhaps as many as a dozen states in sub Saharan Africa and parts of Asia being particularly vulnerable. The International Crisis Group ‘links the AIDS pandemic to deteriorations in national and even global security by promoting human migration, creating orphans, threatening social and economic progress and affecting police and civil service capability.’ They also warn that AIDS has had such an impact on several African armies that it ‘is interfering with peacekeeping operations in some parts of sub-Saharan Africa’ (ICG, 2001). The UNAIDS 2006 report highlights AIDS’ impact on other parts of African societies, drawing attention to how, in Botswana, 17% of the healthcare workers died due to AIDS between 1999 and 2005 whilst in South Africa, the figure was close to 21% for teachers between the ages of 25 and 34. UNAIDS also predicted that some 20% of Namibia’s agricultural labour force will perish by 2020 as a result of the disease.

In addition to HIV/AIDS, Malaria is also a powerful metaphor for the relationship between declining health indicators, economic stagnation and a growing potential for conflict. In particular there has been a growing recognition that malaria tends to be a causal factor rather than a simple symptom of poverty - placing a significant burden on the medical systems of states and demonstrating a strongly negative impact on
economic productivity (Gallup and Sachs, 2001). The combination of disease, poverty, social and economic exclusion and unresponsive governments are increasingly described as creating a stronger predisposition towards instability and conflict (Murray et al., 2002; Stewart, 2002) whilst globalisation has heightened the risks of destabilising disease transmission across international boundaries. Furthermore, in highlighting the complexity of this process Esty et al. (Esty et al., 1999) suggest that high infant mortality rates are significant predictors of state failure through coups d’état, civil strife and other means - concluding that infant and maternal mortality rates are powerful proxies for the overall quality of material life.

**Destabilising Impact of Disease**

- Reductions in agricultural productivity.
- Abandonment of agricultural lands leading to food insecurity.
- Reductions in access to education and future wages.
- Adverse child and maternal health.
- Hollowing out of public service delivery – security, health, education, etc infrastructure.
- Burden on health care system.
- Community destabilisation.

*Health Interventions as tools of Stability and Stabilisation*

The potential impact of disease on state and regional stability has been responsible in part for generating increasing interest in health as an instrument of diplomacy and national security. Within parts of the health community this has been characterised as an opportunity to align foreign policy behind health goals. Kickbusch et al for example claim that ‘foreign policy is now being driven substantially by health’ whilst Horton concludes that health can now move “foreign policy away from a debate about interests to one about global altruism” (Horton, 2007). However, whilst initiatives such as the UK *Health is Global* 4 clearly fall within this approach there is

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4 ‘Health is global’ was launched in September 2008 and outlines the UK’s cross government strategy for improving global health outcomes.
also a potential for health interventions to be used as instruments of state strategic policy. Authors, such as Feldbaum & Michaud (Feldbaum and Michaud, 2010) offer a more measured analysis to that of Horton, suggesting instead that whilst this trend may indeed provide an opportunity for promoting health outcomes, traditional foreign policy interests continue to ‘play a critical role in determining which global health issues achieve political priority and attract funding.’ Furthermore they point to the tendency for states to instrumentalise ‘health initiatives as a means to improve security, project power and influence, improve their international image, or support other traditional foreign policy objectives.’ Secretary of State Clinton appeared to lend credence to Feldbaum & Michaud’s analysis, highlighting the increasing complexity of language around health interventions and stressing that ‘we understand that addressing global health challenges is not just a humanitarian imperative -- it will also bolster global security, foster political stability and promote economic growth and development’ (State Department, 2010).

The increasing post Cold War strategic significance of fragile states has also increased the complex of factors shaping health interventions. Particularly since 9/11 fragile states have been portrayed as presenting challenges both from a security perspective (as a major driver of instability and insecurity) and as a key challenge to delivering the Millennium Development Goals (‘MDGs’) (USAID 2004; DFID 2009). Darcy and Pavanello argue that this interest in fragile states as critical foreign policy problem has paralleled the growing focus on supporting fragile state public ‘service delivery’ – which itself was placed at the heart of the development agenda in 2004 by the World Bank 2004 World Development Report: Making Services Work for the Poor (Darcy and Pavanello, 2009) as a means of addressing state fragility.

Consequently service delivery strategies - particularly in areas such as health care, education and water/sanitation and rural infrastructure have increasingly been conceived as critical building blocks in developing fragile state’s performance legitimacy in ways that are necessary both for the fragile state’s immediate survival and for its longer term growth (Garcia, 2006 (OECD 2007, OECD 2008, Newbrander 2007, DFID 2005). Darcy & Pavanello, amongst many others, argue that failures in service delivery by states are strongly linked to state fragility, citing the OECD’s
recognition that ‘fragility has a major impact on service delivery. At the same time, programs to improve service delivery systems and outcomes have the potential to help reduce state fragility’ (OECD/OCDE 2006). Furthermore, they suggest that service delivery could have broader transformative effects - arguing that ‘improvements in service delivery in one sector can have positive spill-over effects on other sectors and on other MDGs and targets. Assistance in service delivery is therefore widely understood as serving as a platform for the initiation of long-term development activities.’ (See also Berry et al 2004, Newbrander 2007 and OECD 2008).

The consensus around supporting a fragile state’s responsiveness to their populations’ expectations has also necessitated increased attention to governance processes – encouraging more attention to the relationships between citizens and the state and the ‘informal and formal institutions that shape individual and collective behaviour.’ (Eldon et al 2008). For DFID ‘improving governance’ is recognised as being ‘at the heart of building an effective, developmental state because it strengthens consensus among different groups in society about how the country’s affairs are managed. This helps to consolidate security and the rule of law. It enables the state to become more stable, with broad legitimacy and capability across all regions and parts of society.’ (DFID, 2007).

The Stabilisation Agenda

Whilst the fragile state agenda focused on the role of service delivery and governance in creating responsive and resilient states the failure of post conflict planning in Iraq and the stalling of the Afghan ‘reconstruction’ programme gave rise to the concept of ‘stabilisation’ - emerging as a powerful policy discourse towards the end of 2004.

Within the UK ‘stabilisation’ was initially conceived by the Post Conflict Reconstruction Unit (PCRU – established in 2004 as the forerunner of the UK Stabilisation Unit in order to facilitate cross government stabilisation planning and delivery) very much in terms of economic and infrastructure reconstruction and service delivery. However, the failure of this model to bring stability to and deliver a ‘social contract’ both in Iraq and Afghanistan encouraged reconsideration. The
Afghan experience was particularly formative, leading practitioners to conclude that a reconstruction-based approach was insufficient to overcome the challenges of chronically poor and predatory governance at the local level. Consequently, the discourse borrowed increasingly from developments in the fragile state literature in order to address the issues both of poor governance and the lack of social capital that characterised the Afghan environment.

The UK approach increasingly focused on supporting the Afghan state to build its legitimacy and develop core capabilities—particularly its survival functions (especially provincial and district leadership and the generation of security structures and institutions), building social capital (within civil society that was capable of connecting with government) and (from 2008 with the adoption of the UK ‘Helmand Road Map’) community ‘voice’ and the capacity of sub-national government structures to connect with the population. This was underpinned with the provision of essential services and some iconic reconstruction projects—known as ‘quick wins.’ This more political approach was reflected in the Stabilisation Unit’s Quick Impact Project Handbook, defining stabilisation as aiming to:

‘support places that are emerging from violent conflict towards a period of peaceful development, often through external military and civilian support to weak host governments. The support is focused on extending the legitimacy and capability of that government and providing immediately tangible benefits to the population—‘quick wins’—that underpin their confidence in the state and the political process that it represents. Stabilisation activities explicitly aim to impact positively upon formal and informal political dynamics at all levels and to contribute to a non-violent political settlement or interim accommodation.’ (Stabilisation QIPs Handbook, 2009)

It goes onto argue that stabilisation may therefore support the development of the state in one or more of the following ways:

• ‘Facilitating a political settlement between parties competing for power
- Supporting the state to fulfil its core functions, such as territorial control and control of the state’s finances
- Facilitating the legitimate government’s ability to deliver what is expected by the population and what gives it its authority to represent them.’

Consequently stabilisation planners have tended to focus on what they describe as the 4 ‘Ps’:

**The objectives of stabilisation – the 4 ‘P’s**

Stabilisation is the process of establishing peace and security in countries affected by conflict and instability. It is the promotion of peaceful political settlement to produce a legitimate indigenous government, which can better serve its people.

Stabilisation often requires external joint military and civilian support to perform some or all of the following tasks: prevent or reduce violence, protect people and key institutions, promote political processes and prepare for longer-term development.

**The objectives of stabilisation**

- **Prevent – or contain – violent conflict**
  This may require coercive as well as political intervention, whilst working towards addressing the causes of underlying tensions. It may also involve active pursuit of groups who refuse to take part in a non-violent political process.

- **Protect people and key assets and institutions**
  Where violence persists, a minimum precondition for stability is the provision (possibly by external military forces acting in support of local ones) of sufficient security for men, women and children to begin going about their daily lives and for government to function.

- **Promote political processes which lead to greater stability**
  The main aim is to achieve political settlements which make it in parties’ interests to contest power and resources peacefully rather than violently.

- **Prepare for longer-term development**
  Stabilisation activities can profoundly affect the chances of successful social and economic development.

The UK approach has tended to avoid the articulation of a universal stabilisation model, instead recognising the necessity for situation specific responses that address a wide range of conflict drivers. Consequently the stabilisation discourse has offered broad principles for engagement rather than prescriptive lists. These have centred on:

‘ending or preventing the re-emergence of violent conflict, buying time for or actively supporting the emergence of a sustainable and more inclusive peace settlement and demonstrating a peace ‘dividend.’ Creating the conditions for non violent politics and more ‘normal’ forms of economic activity and establishing the legitimacy of the government.’ (PCRU ‘Hot stabilisation paper,’ Unpublished mimeo, 2006).

This approach has tended to contrast with the more prescriptive lists of stabilisation functions and priorities promulgated by USIP and RAND, the intellectual driving forces behind much US thinking (Bensahel et al, 2009; USIP, 2009).

The result of this approach has been that UK stabilisation programmes have tended to be highly context dependent, reflecting the interrelationship of three principal variables: the range of conflict drivers particular to a given context (and societal capacities to contain them); public expectations and a very pragmatic recognition of the limits of the possible. These variables have appeared to drive the relative balance between ‘political engagement, security efforts, and reconstruction and development activities.’ (Mina Jarvenpaa, 2008). However, and demonstrating some convergence with US thinking, some factors are viewed as being likely to be components of most stabilisation programmes: a relatively inclusive political process, a capacity for the state to provide a ‘degree’ of security and demonstrate some improvements in basic infrastructure and services in order to be perceived as internally legitimate.

‘Political engagement and strategic communication efforts; ceasefire negotiations, or laying the groundwork for a political deal. Establishing a secure environment will always be an early stabilisation priority, immediately
followed by a focus on policing and justice, as well as ensuring basic financial functions including the payment of civil service salaries.’ (Jarvenpaa, 2008)

The result of this more ‘political’ engagement with stabilisation has been a degree of convergence with the development community’s approach to governance issues. From the 1990s onwards the quality of governance has increasingly been recognised as a critical factor in shaping the prospects for development in fragile states and contemporary debates on governance are no longer limited to discussions of the formal institutions of the state. Instead they extend to ‘the interaction between formal and informal institutions, rules, processes and relationships. It is a process of bargaining between those who hold power and those who seek to influence it.’ (DFID, 2008) This broader focus has resulted in greater attention being paid to the capacity of beneficiaries to express their views and shape government priorities and, as a consequence, citizen’s ‘voice’ and accountability mechanisms (CV&A) within government structures have increased in importance. Menocal and Sharma (2008) stress this, arguing that ‘citizens need effective ‘voice’ in order to convey their views; and governments or states that can be held accountable for their actions are more likely to respond to the needs and demands articulated by their population.’ They suggest that this approach has become a critical part of the new development orthodoxy and, whilst recognising that donors differ in terms of their terminology, the core principles underpinning citizen voice and accountability – which they describe as participation, inclusion, accountability and transparency – consistently shape international development interventions. DFID in particular has increasingly focused support on developing effective governance interventions, signalling its growing focus on such issues in its 2001 Target Strategy Paper: *Making Governance Work for Poor People* whilst the 2006 White Paper introduced the capability, accountability and responsiveness (CAR – see below) framework as the critical pillars of its approach.
Despite the increased focus on CV&A it lacks effective operationalisation. In part this results from the obvious difficulty in indentifying indicators that can ‘simplify and capture complex processes and relationships that are transformed through V&A interventions.’ (Holland et al, 2009). Menocal and Sharma (2008) suggest that whilst donors have been relatively successful in increasing the ‘voice’ of marginalised groups it has been far more challenging ‘for that voice to be effectively engaged in accountability relations (meaning that rights are secured and relationships transformed).’ The explanation for the difficulty in delivering this is partly provided by Holland et al (2009) who suggest that many V&A projects ‘involve a leap of faith that assumes that by building awareness of rights among rights holders, or by strengthening the capacity for responsiveness amongst duty-bearers, there will be an automatic change of behaviour and power relations that will lead the project seamlessly into an improved set of outcomes.’ Their proposed remedy is to develop V&A based output indicators that increase ‘the visibility of behavioural change indicators at the output level in the logframes’ enabling us to ‘interrogate this ‘leap of faith’.’ They suggest that this can be done by ‘measuring and testing assumptions about the effect of project inputs, such as capacity-building, and the subsequent impact of changed behaviour on project outcomes.’ (Holland et al, 2009). Arguably
without developing effective indicators for CV&A it will continue to be difficult to determine the impact of health programmes and CV&A interventions on state legitimacy.

Despite these challenges the Helmand Road Map, the UK’s stabilisation plan for Helmand adopted in April 2008, increased attention on supporting the emergence of all three aspects of the CAR framework. However, practitioners also recognised that this framework represented a very long term objective of the Helmand intervention and, by the end of 2009, were unable to operationalise indicators that adequately captured changes in the processes implied by Holland et al’s ‘leap of faith’.

Whilst stabilisation objectives increasingly appear to be ambitious the contribution made by external actors was frequently characterised by interviewees in very limited terms, reflecting a perceived inability for external actors to impose a political settlement or to adopt a role as the principal force generating public confidence in a government. This was, however, balanced by a ‘a recognition that external inputs can compensate for the weakness of domestic institutions and support the development of a narrative about the benefits of peace that can support political processes and develop momentum towards and buy time for political processes.’ In this model the restoration of critical infrastructure and service delivery more generally was frequently characterised ‘as having the potential to consolidate trust in the political process and potentially creating the conditions for longer term and more sustainable forms of development assistance.’ (Jarvenpaa, 2008)

The stabilisation discourse has also tended to differentiate a sub set of ‘hot stabilisation’ activities in which military led counter insurgency (COIN) merges with civilian led discourses. Clearly focused on Iraq and Afghanistan, this has focused on the role of outsiders in enforcing aspects of a settlement through the defeat of an insurgency whilst simultaneously cementing support for a domestically owned process of ‘transition’ towards peace as well as building societal capacities to resist conflict drivers. This subset of stabilisation includes a stronger sense that the external role is in supporting the defeat of those who oppose violently the political process, although with military activities that do not exacerbate the conflict and are intended to be sensitive to the conflict dynamic.
Securitisation of Service Delivery

Whilst service delivery and governance reform were increasingly portrayed within the stabilisation and development literatures (DFID, 2007) as critical instruments in the transformation of fragile states into resilient and responsive structures, this approach has also appeared in the new military counter insurgency (Land Warfare Centre, US JDP and JDPs 3-40 and 3-50 and 3-52) and civilian stabilisation models (Stabilisation Guide and QIPs Guide) leading to a sense of the ‘securitisation’ of assistance (Muggah, R. 2009). Within these models service delivery, including the provision of basic health care services, was widely (particularly within US and UK military circles) viewed as a key component in winning the ‘hearts and minds’ of beneficiary populations as well as delivering security benefits – usually defined in terms of increased access to intelligence and information that enhanced the force’s own protection but also pitched in terms of precipitating broader positive attitudinal change amongst beneficiary populations (Newton, 2009).

Within this approach both the US and UK military’s attached great importance to health and development interventions as ‘soft power’ instruments (Brigety, 2006; Baker 2007; Vanderwagen 2006; UK MOD JDP 3-40) that were critical to the consolidation of conventional tactical military successes. Both militaries sought to incorporate a range of medical interventions – the use of military hospital ships and medical evacuations for treating wounded host nation civilians, financial and technical support to host nation medical infrastructure regeneration, military medical outreach programmes (clinics) and PRT support to domestic health services largely in support of military and political objectives (Rosenberg 2007; Brigety 2008; Baker 2007; US GAO 2008).

Conceptualising Stabilisation

Whilst the UK has published a credible definition of ‘stabilisation’ that appears ‘fixed’ the reality is that the process of setting stabilisation priorities is highly context dependent. In Afghanistan it has tended to involve:

- Supporting state survival functions.
- Addressing conflict drivers directly.
Preserving and developing social capital that can ameliorate conflict drivers.
Preserving and restoring critical infrastructure.
Building state performance legitimacy through supporting its capacity to deliver public services.
Improving governance through supporting citizen voice and governmental accountability.
Supporting the state’s political outreach in support of a political settlement.

Health and Stabilisation
The health literature has clearly not been immune to these debates. The growth and evolution of the stabilisation discourse in both the UK and the US has affected perceptions of the potential role for health interventions in fragile and conflict states. However, whilst donor interventions in Afghanistan and Iraq have included significant investments in health programmes, their role in producing stabilisation outcomes has remained unclear (Rubinstein 2008 and chapter 3 of this paper). In part this is a reflection of the continuing evolution, imprecision and flexibility of the stabilisation concept. However, it also reflects a somewhat schizophrenic set of aspirations towards health interventions. Whilst health practitioners are frequently anxious to harness health goals to foreign policy and strategic objectives as a means for improving health outcomes there is also a potential for health to be instrumentalised in support of interest based foreign policy objectives with potentially adverse and unintended consequences for health outcomes. The following chapter will define the range of ‘stabilisation’ objectives that are ascribed to health interventions.

Findings

‘Stabilisation’ is not a clearly defined concept and ‘stabilisation programmes’ are strongly context dependent.
Stabilisation concepts rely on improvements in governance, service delivery and limited external support for state survival functions. In Afghanistan’s Helmand Province there was also a focus on developing community voice and governmental accountability at the Provincial and District levels.
- They also tend to focus on supporting a political settlement or, where this is absent, on developing social capital which can lead to civil society engaging with and making demands upon government.
- Health interventions have evolved from simply being concerned with addressing health outcomes to addressing societally destabilising factors and being a potential strategic instrument of states.
Chapter Three: Health Interventions and Broader Objectives: Tracking Theories of Change

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<tr>
<td><strong>Aim</strong></td>
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<tr>
<td>This chapter:</td>
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<tr>
<td>➢ Explains how the literature captures the mechanisms through which health interventions are thought to contribute to ‘stability’ in conflict and post conflict environments (‘Theories of change’).</td>
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<td>➢ Details different stakeholder’s attitudes and approaches towards stabilisation and the role of health interventions in this framework.</td>
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<td><strong>Findings</strong></td>
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<td>➢ Prevention of conflict or reduction in conflict levels through highlighting the costs of conflict.</td>
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<td>➢ Peacemaking in conflict. Peacemaking relies on the idea that belligerents have a common interest in healthcare provision and this will be sufficient to overcome political or strategic obstacles to dialogue. Typically this enables negotiated access, often around programmes providing for the immunisation of children. This process is seen as being able to generate trust that is sufficient to enable broader negotiations that can ameliorate the effects of violence and lead to broader peace processes.</td>
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<td>➢ Peacebuilding after conflict. The peacebuilding approach is based on the belief that where health provision improves this will have a positive impact on the legitimacy of governments. Arguably there are three components to this: the first is a general sense that public service provision enhances government <em>performance legitimacy</em> and perceptions of <em>responsiveness</em> thereby reducing societal propensity towards conflict; the second is that carefully targeted health interventions help to undercut grievances based on a group’s (ethnic, religious or tribal) belief that government service provision in inequitable and thirdly that health issues can be a vanguard of reintegration and demobilisation processes.</td>
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<td>➢ The drivers of military involvement in health issues include:</td>
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<td>o International humanitarian law obligations.</td>
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- The ‘Hearts and Minds’ logic.
- Mirroring of (Potential) Enemy Forces or Strategic Competitors
- The interaction between spare military medical capacity and medical ethics.
- Differential clinical capabilities between ISAF and the Afghan health system resulting in patient transfer issues.
- Support to state performance legitimacy through Public Service Delivery.

There is a degree of confusion as to how stabilisation relates to other policy discourses – particularly the UN’s early recovery concept. To some extent these may be competing discourses with early recovery seeking to maintain a closer connection to humanitarian principles than stabilisation appears to allow.

Humanitarian assistance and public service delivery more generally have clearly been politicised in many conflict contexts with the threat of denial or control of the resources becoming an instrument of strategic leverage throughout the Cold War and its aftermath, most notably in Bosnia-Herzegovina, Somalia and Rwanda. However, there are occasions where its role is viewed less as providing an instrument for coercion and delivering strategic advantage and more as a mechanism for encouraging processes that are inherently stabilising. For example, Pavignani and Colombo describe how in the aftermath of the Mozambique conflict the integration of RENAMO health workers into the state health infrastructure helped to promote reconciliation (Pavignani and Colombo 2001) whilst the WHO record how in 1985 in El Salvador immunization campaigns led to a ceasefires, labelled ‘Days of Tranquillity’ (WHO 2002). Kruk et al, quote Rodriguez-Garcia et al’s findings that ‘combatants have been persuaded to lay down arms albeit usually briefly to permit polio and other vaccinations in conflict-affected areas (Rodriguez-Garcia, Schlesser, & Bernstein, 2001 quoted in Kruk et al 2010). The role of health in creating opportunities for former belligerents to engage in a more peaceful dialogue has been labelled ‘health as a bridge for peace’ (or HBP). This relies on the proposition that health has unique value to belligerents regardless of their political affiliation or wider
strategic interests (MacQueen, McCutcheon, & Santa Barbara, 1997; Santa Barbara & MacQueen, 2004; Sirkin, Facci Cali, & Keough, 2007) and enables health practitioners to use health interventions in order to create ‘space’ for other processes that have the potential to have a broader effect in ameliorating conflict.

The HBP’s origins appear to be in the NGO and the peace studies community and derive from a sense that the reduction in mortality and morbidity rates brought about through health based interventions have been insufficient in conflict environments. Whilst the strongest advocates of HBP appear to be within the NGO community rather than international health agencies, the agenda received credible support from the World Health Organization who began a ‘Health as a Bridge for Peace’ programme in August 1997. This was accepted by the World Health Assembly in May of the following year and attempts to reconcile ‘peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development’ (WHO, 2006). The HBP concept also, initially at least, received strong support from DFID – although subsequently the policy has, to paraphrase Rushton & McInnes (Rushton & McInnes, 2006), mysteriously disappeared in part due to a lack of supporting evidence and also due to the absence of institutional memory within DFID. Nevertheless, there is a considerable and growing peer reviewed literature that elaborates on HBP (Brennan & Sondorp, 2006; Ciro et al, 2002; Vass, 2001; Anderson, 1996; Rushton, 2005; Jones et al., 2006).

Michael Thieren (Thieren, 2007) argues that this ‘multidimensional framework claims to aid peace efforts by enabling communication between warring parties on matters not related to their conflict. The project aims to create a technical space in which opposing groups can agree on such issues as health-care norms and guidelines, epidemiological information exchanges and health system reform strategies.’ Arguably there are three relatively distinct strands to the HBP concept. These can perhaps best be described as ‘preventive’, ‘peacemaking’ and ‘peacebuilding’ ‘bridges.’ The mechanism through which ‘peace’ is built is somewhat different in each case but reflects much of the underlying logic of ‘stabilisation’:
<table>
<thead>
<tr>
<th>Prevention of conflict or reduction of violence during conflict</th>
<th>Peacemaking in conflict</th>
<th>Peacebuilding after conflict</th>
</tr>
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<tbody>
<tr>
<td>Prevention is very similar to the traditional NGO role of advocacy – in part explaining the appeal of HBP to NGO practitioners. The core idea is that advocacy programmes will inform the public and governments of the real costs of violence and reduce the incentives for warfare whilst also mobilising international support for a range of processes that will contribute to a cessation of hostilities.</td>
<td>Peacemaking relies on the idea that belligerents have a common interest in healthcare provision and this will be sufficient to overcome political or strategic obstacles to dialogue. Typically this enables negotiated access, often around programmes providing for the immunisation of children. This process is seen as being able to generate trust that is sufficient to enable broader negotiations that can ameliorate the effects of violence and lead to broader peace processes.</td>
<td>The peacebuilding approach is based on the belief that where health provision improves this will have a positive impact on the legitimacy of governments. Arguably there are two components to this: the first is a general sense that public service provision enhances government legitimacy and reduces societal propensity towards conflict; the second is that carefully targeted health interventions help to undercut destabilising grievances based on a group’s (ethnic, religious or tribal) belief that government service provision in inequitable.</td>
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**Health, Conflict Prevention and Advocacy**

The proposition that health interventions have a role in conflict ‘prevention’ is based on two ideas – firstly that well constructed health programmes can ameliorate conflict
drivers (e.g. through reducing social exclusion) thereby making conflict less likely and secondly that advocacy programmes based on epidemiological studies of mortality and morbidity can strengthen opposition to warfare as a result of highlighting its true costs. Whilst the former is not dealt with due as a prevention mechanism (due to this paper’s focus on conflict stabilisation) it is dealt with as an aspect of peacebuilding.

The increasingly political role of epidemiological studies is a product both of humanitarian advocacy concepts and the emergence of conflict epidemiology as a discipline. Whilst difficult to demonstrate that this approach has ‘preventive’ or ‘ameliorative’ effects within a conflict state there is anecdotal but reasonable evidence that these campaigns do have the capacity to lead to better engagement from international donors once crises begin and that this can mobilise political and material resources that can ameliorate some aspects of conflict. Numerous advocacy programmes have focused attention on conflicts such as those in Sierra Leone, Darfur, DRC, etc and have provided a focus on specific issues such as the prevalence of rape in the DRC, malnutrition in Sudan, ethnic cleansing in Bosnia and Darfur and civilian ‘collateral’ damage in Iraq and Afghanistan. Thieren argues that ‘both political and technical messages are sent by death tolls or rates; by numbers of missing, displaced and injured; and by statistics showing relative access to health services, food and safe water. Despite the difficulties of collecting data in disaster areas, the emerging practice of conflict epidemiology offers effective measurement methods that can generate reliable numbers to guide strategic decisions and influence political leaders.’ (Thieren, 2005)

Health Interventions and Peacemaking

Paula Gutlove (Gutlove, 2009) describes the logic of HBP in peacemaking as resulting from the ability of health professionals to ‘create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation.’ She argues that health professionals have a unique capacity to facilitate co-operative dialogue due to recognition of their neutral and humanitarian mandates and that technical/medical dialogues about healthcare and access to beneficiaries can deliver trust sufficient for
the initial dialogue to expand into other areas of mediation and conflict resolution. Thieren suggests a similar process, arguing that it ‘claims to aid peace efforts by enabling communication between warring parties on matters not related to their conflict. The project aims to create a technical space in which opposing groups can agree on such issues as health-care norms and guidelines, epidemiological information exchanges and health system reform strategies.’

Gutlove also draws attention to numerous examples of ceasefires based around negotiated humanitarian access (often around child immunisation programmes or food deliveries) with her strongest example being drawn from Afghanistan where, in 1994, the WHO and the Afghan Ministry of Public Health brokered a 2 week ceasefire to enable child immunisation throughout the country. This was later extended both in time and scale – becoming a 2 month mass immunisation campaign. Some authors also suggests that negotiating ceasefires for health access can be viewed as potentially having ‘spill-over effects in terms of building trust among conflicting parties’ (Rodriquez-Garcia et al, 2001). The WHO has sought to compile a database of examples where health interventions have led to ceasefires.

A variant on this approach is recorded by USAID. In Sudan USAID prioritised health programmes in areas where the potential for renewed hostilities was greatest (USAID, 2007) despite these being areas that had comparatively fewer health needs. Similarly international support for the rapid role out of the Afghan BPHS was partly intended to ensure the programme was seen to provide a peace dividend.

Anthony Zwi (Zwi et al 2009) extends this into the normative domain by suggesting that health is a bridge to peace by promoting an ethos of non discrimination and respect and providing a neutral political space, providing a model of collaboration across society and giving a sense of cohesion and belonging to communities - although he does clarify that in ‘extreme contexts’ health care may be only able to “save lives” because the ‘pursuit of peace... is not feasible’ due to conflict.
Health Interventions and Peacebuilding

The peacebuilding approach is based on the assumption that where health provision improves this will have a positive impact on the overall legitimacy of governments. Arguably there are three components to this: the first is a general sense that public service provision enhances government performance legitimacy and perceptions of responsiveness thereby reducing societal propensity towards conflict; the second is that carefully targeted health interventions help to undercut grievances based on a group’s (ethnic, religious or tribal) belief that government service provision in inequitable and thirdly that health issues can be a vanguard of reintegration and demobilisation processes and that cooperative processes in health are a useful entry point for stimulating broader co-operation.

Health is also frequently cited as part of a peace dividend following a broader peace settlement with agreement on a Basic Package of Health Services (BPHS) viewed as one possible entry point in cementing a fragile process. Waldman (Waldman, 2006) argues that in DRC the BPHS ‘development was a political and a technical event in that it brought together, for the first time since hostilities broke out, health authorities working under the jurisdiction of all the important armed political factions at the time.’ In other papers the bridge for peace idea is more explicitly associated with the reintegration of former belligerents. Pavignani and Colombo (Pavignani and Colombo 2001) cite the example of Mozambique where the effort to reintegrate RENAMO health workers into the health workforce was viewed as promoting reconciliation.

Kruk et al provide a useful summary of the peace and statebuilding aspirations (Kruk, Freedman, Anglin and Waldman, 2010) – arguing that the careful design of these ‘health system building blocks – including the regulatory framework, resource allocation, financing, package of services, mode of delivery, human resource management, etc- can build government capacity, promote social cohesion, and strengthen the social contract, thereby promoting statebuilding and reducing the risks of conflict recurrence.’ (Kruk et al, 2010). Rubenstein echoes this suggesting that the ‘most commonly cited potential benefits of service delivery in post-conflict environments are that visible delivery enhances state legitimacy, strengthens the
social contract and hence, promotes state building. Delivery of services can also address underlying causes of conflict, i.e. social exclusion, and services such as health can be used as entry point for wider peace-building processes.’ (Rubenstein, 2009). Fritz and Menocal (Fritz and Menocal, 2008) take this further, suggesting that state-building can be ‘significantly enhanced by well-targeted, responsive international assistance to build capacity, institutions and legitimacy. They draw particular attention to the “state-society compact” and its institutionalization through ‘political process or accountability mechanisms through which the state and society reconcile their expectations of one another.’ Eldon et al also echo these aspirations but introduce a strong note of caution, suggesting that ‘health sector strengthening can contribute to state building in the health sector. It can help build legitimacy and capacity, and put health on the state-building agenda. Context is the key influencer of potential for state-building, but it is often inadequately understood. However, the extent of state-building within the health sector is not systematically understood and more evidence is needed. For instance, there is little, if any, clear evidence on the relationship between health system strengthening, citizen and state expectations and the social compact.’ (Waddington et al 2008).

Stabilisation and Military Health Interventions

Whilst the UK and US military have been heavily involved in the provision of medical care to host nation civilians in both Iraq and Afghanistan this is not the first example of such involvement. The UK experimented with medical support to civilians in both the Malayan and Omani counter insurgency operations and the RAND study on the role of health in reconstruction operations (Jones, 2006) details at length the military role in the provision of health services in numerous post conflict reconstruction environments. Similarly Robert Wilensky (Wilensky, 2006) charts the numerous civilian medical outreach programmes (PHAP (Provincial Health Assistance Program), MILPHAP (Military Provincial Health Assistance Program), MEDCAP (Medical Civic Action Program), and CWCP (Civilian War Casualty Program) run by the US military in the course of the Vietnam War. Within Afghanistan the majority of Provincial Reconstruction Teams and ISAF itself have some type of medical programme ostensibly linked to the stabilisation agenda. Often this leads to direct
military participation in identifying and funding health projects or in delivering basic health care services.

Drivers of Military Involvement
The review of the literature in this area suggests that there are six principal and interlinked drivers of military involvement in the health sector. The first of these is derived from the UK’s International Humanitarian Law obligations. The Fourth Geneva Convention, places a number of obligations on an occupying power in terms of addressing the civilian population’s food and health needs. These are summarised in the table below:

IHL Obligations of the Occupying Power Under the Fourth Geneva Convention:

- Ensure food and medical supplies for the civilian population, especially if the resources of the occupied territory are inadequate, employing the “fullest extent of the means available to it. (Article 55)
- Ensure the effective operation of medical services, including hospitals and public health programs, with special focus on preventing the spread of contagious diseases and epidemics, and allow medical personnel to carry out their duties. (Article 56)
- Facilitate relief programs for the civilian population “by all the means at its disposal.” (Article 59)
- Maintain “preferential measures in regards to food, medical care, and protection” in favor of children under 15 years, expectant mothers, and mothers of children under seven. (Article 50)
- Maintain all institutions devoted to the care and education of children. (Article 50)
- Facilitate access of humanitarian personnel. (Article 30)


The remaining drivers include the ‘hearts and minds’ logic; pressure to mirror the capabilities of potential or actual enemy forces; incentives created by ‘spare capacity’ in the military medical services, issues surrounding differential clinical
capabilities between ISAF and the Afghan health system – leading to difficulties in arranging patient transfer from military medical facilities and the traditional public service delivery argument. A further driver, albeit perhaps less powerful (in the sense of having an impact on the civilian health care system), has been the effort by NATO forces to build up the capability of the Afghan military medical services.

### Drivers of Military Involvement in Health Provision

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<tr>
<th>Category</th>
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<tr>
<td><strong>International Humanitarian Law Obligations</strong></td>
<td>IHL obligations largely under the Fourth Geneva Convention</td>
</tr>
<tr>
<td><strong>‘Hearts and Minds’</strong></td>
<td>Strategic value in engaging with the civilian population leading to information/Intelligence sharing and attitude change primarily toward the military but also to the host government.</td>
</tr>
<tr>
<td><strong>‘Mirroring’ of Potential Enemy Forces or Strategic Competitors</strong></td>
<td>Whilst lacking its own clear theory of change this approach tends to focus on mirroring the evolution in the political arsenals of potential ‘asymmetric’ foes such as Hezbollah or strategic rivals such as China.</td>
</tr>
<tr>
<td><strong>Spare capacity and medical ethics</strong></td>
<td>Surplus military medical capacity combined with medical ethics and an eagerness to contribute.</td>
</tr>
<tr>
<td><strong>Differential clinical capabilities between ISAF and the Afghan health system - patient transfer issues</strong></td>
<td>The requirement to hand-over Afghan patients (Afghan National Army and civilians) from ISAF hospitals to much weaker Afghan medical facilities has encouraged ISAF military support for the infrastructure of civilian hospital facilities.</td>
</tr>
<tr>
<td><strong>Public Service Delivery</strong></td>
<td>The perceived requirement to expedite the process of public service delivery by the Afghan authorities.</td>
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<tr>
<td><strong>Security Sector Reform</strong></td>
<td>Reforming host nation medical support to its security forces both as a recruiting incentive and to boost its fighting morale.</td>
</tr>
<tr>
<td><strong>International Humanitarian Law</strong></td>
<td>IHL obligations largely under the Fourth</td>
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<td>Obligations</td>
<td>Geneva Convention</td>
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**Hearts and Minds**

The ‘hearts and minds’ agenda is based on the belief that providing basic medical support to the civilian population will be of strategic value and military commanders from all specialisations stress the vital nature of being able to interact with the local population in a counter insurgency operation. Medical Civic Action Programmes (or Medcaps for short) are frequently viewed as a key instrument in this process, with basic health care being provided in order to develop ‘influence and intelligence opportunities’ – encouraging populations to share information and changing underlying attitudes to the military force and the Afghan Government (QIPs Guide 2008 and Bricknell 2007). In addition to medical support the UK and US militaries have also sought to provide dental and veterinary support. Bricknell argues that they ‘provide access to health care that might otherwise not be available and they provide an opportunity for military forces to engage with the local community and provide a practical benefit at an individual level. On the negative side, single, one-off medical treatments are unlikely to have any significant health outcome and there have been allegations that these activities have been driven by the military objectives in gathering intelligence rather than any health care benefit.’ (Bricknell, 2007). The UK military have no ‘doctrine’ specifically addressing the role of medcaps or military medical outreach (an alternative term that is sometimes used).

**Mirroring of (Potential) Enemy Forces or Strategic Competitors**
Whilst the pressure to copy enemy forces is not a powerful factor within the British military it has significantly more purchase within US structures and, consequently, the US has used a variety of military led medical interventions to build influence in the Horn of Africa, Iraq, Afghanistan and a range of Latin American and Asian states (Baker, 2007; Vanderwagen, 2007 and Timboe, 2008).

There is considerable evidence that strategic rivals to the US use medical services for essentially political reasons. Horton, for example, describes how, since the mid 1960s, Cuba has used medical diplomacy to buy influence within over a hundred Latin American and African states (Horton, 2007, Keck 2007) through the provision of free medical education to doctors and nurses from other states and, argues Feldbaum (Feldbaum, 2010) earning preferential rates for Venezuelan oil in exchange for primary health care services. Feldbaum also suggests that Brazil is ‘leveraging its model fight against HIV/AIDS into expanded South–South assistance and leadership, accruing “access to markets and diplomatic influence” in service of Brazil’s foreign policy objectives to win a seat on the United Nations Security Council and a greater voice in the international monetary system.

In terms of potential strategic rivals China built its first purpose built hospital ship in 1998, named Ship 866. The Type 920 hospital ship platform is intended to provide potential support to Chinese land missions and offer a useful platform for regional health diplomacy (David Axe, 2008).

Similarly, Burkle describes how both the Taliban (prior to their fall in 2001) and the Iraqi insurgency sought influence over the population through controlling the medical services whilst interviews in Helmand in 2009 revealed how the Taliban had appeared to ape the ISAF ‘hearts and minds’ strategy though providing limited medical services to the civilian population in at least two locations. Bonventre also points to the way in which other non state armed actors have provided public services in order to develop their legitimacy; describing how in the aftermath of Israel’s invasion of Lebanon in 2006 Hezbollah flew wounded Palestinian civilians to Tehran for medical attention, immediately provided cash payments to families made homeless by the fighting and offered free medical care to the dependents of Hezbollah combatants killed in action (see also Cammett, 2009). Similarly a number
of hard line Islamist groups deployed medical services following the October 2005 earthquake in Kashmir. The Al-Khidmet Foundation, linked to the Islamist party Jamaat-e Islami, provided relief convoys, medical facilities and displaced persons camps and sought to ‘recruit children orphaned by the earthquake to its cause’ (Bonventre, 2010). Whilst still serving as a Senator, Jo Biden warned of the way in which Jamaat ud-Dawa, an offshoot of al-Qaeda, deployed two field hospitals to Kashmir (Biden, 2007).

**Spare Capacity**

Christopher Bulstrode (Bulstrode interview 2009) suggests that the combination of increased medical need amongst civilians in conflict situations and the spare capacity inherent within the military medical service acts as a driver of military involvement in direct health provision. He states that ‘any well-equipped military force should have adequate medical support to cover most eventualities. This will inevitably mean that in all but the most ‘kinetic’ situations there will be spare capacity to take on other perceived needs, such as providing medical care to the local population. The sight of the illness and poverty in a third world country makes all military personnel (both medics and non-medics) eager to do something to help.’

Furthermore, the existence of significant medical capabilities with significant (albeit temporary) spare capacity alongside weakly regulated discretionary quick impact project funding appears to create powerful opportunities for military medical branches to become involved in even national health policy issues. Bricknell, a former senior ISAF Medical Officer, phrases this in terms of an obligation, stating that ‘Afghanistan has amongst the worst population-level health indicators in the whole world. As an institution, the ISAF military medical services are one of the largest international medical organisations operating in Afghanistan. The use of this capability in support of health sector reconstruction and development is both a military task and a professional obligation.’ (Bricknell, 2007).

**Patient Transfers**

In terms of patient transfer issues Bricknell argues that the process of transferring patients from ISAF medical facilities is fraught with practical and ethical challenges. Two clinical scenarios in particular present difficulties: the treatment of burns and head injuries, particularly in children. Bricknell argues that in both ‘cases the
management of the acute phase in severe cases is within the clinical capability of the majority of ISAF medical facilities but, for survivors, is likely to lead to substantial challenges in long-term care and rehabilitation that may be beyond the capability of local medical facilities and beyond the financial resources of the patient’s family.’ He suggests that this leads to difficult choices in triage and a recognition that ‘a pain-free, dignified death locally within the family environment might be better than a long, drawn out demise with possibly a complicated patient transfer to a distant hospital away from relatives and the consequent challenge of burial in accordance with religious customs.’ Bulstrode argues that in addition to the clinical issues raised by patient transfers ‘the movement of the patient’s relatives to provide personal care in the receiving hospital, confirmation that the family can pay for any drugs needed (as about 70% of drugs are purchased by patients) and a plan for the return of the patient to their home location after completion of care. Our experience of a number of patient transfers proved that, in spite of our best efforts, even the simplest thing can go wrong.’ Both situations have led to ISAF medical officers engaging in stock takes of Afghan medical capabilities and often the provision of basic or critical equipment through military quick impact project budgets (QIPs Evaluation 2007 & Bricknell & Hanhart, 2007).

Public Service Delivery
A further driver is the use of military capacity in support of state civilian health delivery in order to promote the state’s performance legitimacy. This has been a particular driver in the Afghan context.

Security Sector Reform
The final driver is in terms of security sector reform - creating a capable military in a host nation. Lt General William Caldwell, Commander of NATO’s Training Mission (NTM) and the Combined Security Transition Command (CSTC-A) in Afghanistan argued during his Royal United Services Institute (RUSI) speech on the 2 March 2010 that the creation of an Afghan military medical service was integral to the creation of a capable Afghan military. This theme was echoed by Bonventre in the context of the Philippines, where he notes that ‘training and equipping the Filipino military health services resulted in a significant increase in the efficacy of the Filipino security forces that are fighting insurgents. Logically, a soldier is more willing to fight
if he knows he will receive quality healthcare if injured.’ Bonventre also provides a more limited logic, arguing that the US ‘Defense HIV/AIDS Prevention Program’ has improved the capability of foreign militaries to cope with the AIDS pandemic – limiting the capacity of the disease to hollow out a states’ security forces.

**Agency and Public Service Provision**

In addition to identifying the dominant theories of change the literature raises questions about ‘agency’ - in particular the relative benefits of health based stabilisation interventions either through host nation governments or by sub contracting through NGOs. Whilst using NGOs has the potential to rapidly scale up service provision it may undermine the association between government and service delivery. Equally, it may reinforce perceptions of government performance legitimacy and responsiveness by increasing access to a vital public service despite being delivered through a sub contractor. This issue has implications for other deliverers – can military or third party states deliver public services on behalf of a host nation in such a way that this still has a positive impact on host state performance legitimacy? In effect does the rapid scaling up of service delivery have a greater impact on government legitimacy than the slow build up of a host nation’s own capacities?

**Stakeholder Approaches to the role of Health in Stabilisation Programming**

The question of ‘agency’ also invites questions about stakeholder attitudes towards and engagement with the stabilisation discourse. Many of the stakeholders interviewed during this research admitted to only a limited understanding of the precise nature of stabilisation and how it differed from other policy discourses. Even within governmental bodies there were marked differences in emphasis and content. These challenges were also felt by many non governmental organisations that still appeared to be grappling with a range of emerging concepts (particularly early recovery and stabilisation) and defining their institutional policies towards them.

Arguably these debates are not new and reflect the nearly two decades of discussions over the relationship between relief and development. Despite the lack
of real progress in defining the relationship between these concepts the increased attention paid towards fragile states has widened the attention beyond simply ‘linking relief and development to integrating aid and security. This has brought to the fore the inevitable tensions between humanitarian, development and security-oriented approaches. Increased attention to stabilisation, peace-building and state-building reflects these security-oriented priorities. Frameworks like ‘early recovery’, are indicative of attempts to help reconcile often divergent objectives and priorities in the transition away from conflict, but with varying interpretations around early recovery and evident trade-offs between different assistance approaches, these challenges remain as stark as ever’ (Collinson et al, 2010; for further elaboration see also Elhawary et al, 2009). Elhawary et al (Elhawary et al, 2009) seek to capture the complexity and overlap of differing policy discourses in the following chart.

The emphasis on different policy labels also reflects self interest and normative values. For example the UN Department of Peacekeeping Operations (UN DPKO) tend not to use the stabilisation label due to its association with the controversial invasion of Iraq in 2003.
Reflecting the idea that stabilisation comes with political baggage Collinson et al (Collinson et al, 2010) argue that ‘Governments affected by crisis may find value in pushing for early recovery if they believe that it will give them more authority and power within the humanitarian response.’ They also highlight that because ‘recovery is seen as more aid-oriented than stabilisation, many aid agencies are more comfortable with pushing for recovery strategies than for stabilisation. For humanitarian agencies who try to distance themselves from the security aspects of stabilisation and the political aspects of peace-building, early recovery could function as a middle ground for promoting livelihoods.’ Nevertheless, they argue that ‘humanitarian agencies generally remain unconvinced about the value of portraying livelihood and other activities in terms of early recovery, in no small part because early recovery is seen as more politicised than humanitarian assistance.’ Their research suggests that NGOs continue to struggle with the risks of politicising aid whilst also seeking to make emergency responses deliver sustainable and enduring effects.

A consequence of these challenges it that it becomes difficult to capture precisely stakeholders’ attitudes towards and engagement with stabilisation. However, the following table offers a model.

<table>
<thead>
<tr>
<th>Stakeholder models of and Engagement with Stabilisation</th>
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<td><strong>Stabilisation Unit</strong></td>
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<td><strong>DFID</strong></td>
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Programmes for rebuilding the legislative and judicial institutions alongside the banking and private sectors of the economy – viewed as the key frameworks necessary for encouraging the social and economic change necessary to underpin a political settlement. Greater sense than the SU that humanitarian interventions are also stabilising through reducing mortality and morbidity (M&M). Programmes are felt to be context dependent and utilise a broad range of aid instruments – budgetary and technical support to ministries, governance and public administrative reform, and humanitarian assistance as appropriate. Limited to work in support of the International Development Act. Strong emphasis on coordination with other donors and host government where appropriate. Also implementation through both State and Non State actors as appropriate.

| UK Military | Military support to civilian led stabilisation largely through providing security, supporting SSR and extending the reach of civilian stabilisation advisers into insecure areas. However, the military will substitute for civilian stabilisation/development advisers and deliver this ‘civil effect’ in situations where insecurity prevents civilians from gaining access to beneficiary communities. As above with focus on a range of health interventions (‘medcaps’) as contributor to ‘hearts and minds’ approach plus International Humanitarian Law (IHL) obligations to the civilian population and wounded enemy combatants. Support to host nation military medical services as a part of SSR and economic regeneration as well as to reduce the challenges inherent in transferring host nation patients between first world military medical facilities and the local hospital system. Limited resources. Strong emphasis on the role of public service provision and ‘medical diplomacy’ in the creation of government performance legitimacy. Significant resources for all aspects of military health diplomacy. |
| US Military | Recognises that health service provision is a function of government but rejects a role for itself as an instrument of stabilisation, statebuilding or counter insurgency. Seeks to maintain ‘humanitarian space’ and to portray MSF’s role as politically neutral and impartial and supporting health |
| NGO – MSF | |
provision where need is great but other actors (such as the state) are unable or unwilling to operate. Strong sense that instrumentalisation of health care risks humanitarian space and the evidential basis is too weak to make compromises. Strong advocacy role. Discomfort with early recovery discourse due to its potential for greater politicisation.

**ICRC**
Similar to the position adopted by MSF.

**NGO – e.g. Save the Children UK**
Seek to maintain ‘humanitarian space’ and support health care provision where need is great but other actors (such as the state) are unable or unwilling to operate. Recognition that health service provision is a function of government and that health care can have stabilising effect while HSS can have a statebuilding role - but rejects proposition that it an instrument of counter insurgency strategies. More accepting of early recovery discourse than MSF etc.

**WHO**
Enthused by the opportunities to raise the profile of and resources available to the health community. Strong emphasis on HSS and positive towards the idea of health having superordinate goals.

**Findings**

- There are three principal models proposed for health having benefits that extend beyond the health sector:
  - Prevention of conflict or reduction in conflict levels through highlighting the costs of conflict.
  - Peacemaking in conflict. Peacemaking relies on the idea that belligerents have a common interest in healthcare provision and this will be sufficient to overcome political or strategic obstacles to dialogue. Typically this enables negotiated access, often around programmes providing for the immunisation of children. This process is seen as being able to generate trust that is sufficient to enable broader negotiations that can ameliorate the effects of violence and lead to broader peace processes.
  - Peacebuilding after conflict. The peacebuilding approach is based on the belief that where health provision improves this will have a positive impact on the legitimacy of governments. Arguably there are three
components to this: the first is a general sense that public service provision enhances government performance legitimacy and perceptions of responsiveness thereby reducing societal propensity towards conflict; the second is that carefully targeted health interventions help to undercut grievances based on a group's (ethnic, religious or tribal) belief that government service provision is inequitable (this can also be employed in order to reduce the risk of conflict prior to a formal outbreak of hostilities) and thirdly that health issues can be a vanguard of reintegration and demobilisation processes.

➢ The drivers of military involvement in health issues include a range of factors several of which are not or are only indirectly related to the ‘stabilisation’ model.
  
  o International humanitarian law obligations.
  o Mirroring of (Potential) Enemy Forces or Strategic Competitors
  o The ‘Hearts and Minds’ logic.
  o The interaction between spare military medical capacity and medical ethics.
  o Differential clinical capabilities between ISAF and the Afghan health system resulting in patient transfer issues.
  o Support to state performance legitimacy through Public Service Delivery
  o Supporting host nation military medical services as part of ‘Security Sector Reform.’

There is a degree of confusion as to how stabilisation relates to other policy discourses – particularly the UN’s early recovery concept. To some extent these may be competing discourses with early recovery seeking to maintain a closer connection to humanitarian principles than stabilisation appears to allow.
Chapter Four: Evaluating the Evidence Base

Aim and Findings

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<tr>
<td>This chapter:</td>
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<tr>
<td>➢ Evaluates the quality of the evidence base for each of the major theories of change and the issue of agency identified in chapter 3.</td>
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<th>Findings</th>
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<tr>
<td>➢ In terms of the evidence base for health having a role in preventing conflict or reducing levels of violence during conflict it is possible to conclude that:</td>
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<tr>
<td>o Epidemiological studies clearly can influence international responses to conflict.</td>
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<td>o Evidence on their impact within conflict states has not been collected systematically.</td>
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<td>➢ In terms of the evidence base for health having a role in peacemaking (during conflict) the evidence is mixed. There is strong evidence in support of humanitarian cease fires based around health access leading to significant reductions in M&amp;M in several conflicts. However, these tend to be examples of ‘humanitarian space’ rather than broader peace processes and many appear to rely on the sense that health interventions are discrete and limited interventions. The literature has been unable to demonstrate that health based access agreements have been responsible for or are significant factors in initiating broader peace processes.</td>
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<td>➢ In terms of the evidence base for health having a role in peacebuilding after conflict the evidence is, once again mixed. The peer reviewed literature does not appear to provide systematic analyses of the extent to which health system strengthening contributes to broader processes of state building and peace consolidation. The evidence base is credible in theory but is generally anecdotal, shaped by author bias and has not been subject to systematic research. Similarly there is little clear evidence of the impact on governmental</td>
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legitimacy of the interaction between health system strengthening, the generation of community ‘voice’ and government ‘accountability’. These are clearly priorities for further empirical research.

- There is no credible evidence that military health ‘hearts and minds’ interventions have a positive impact on beneficiary community attitudes. In part this is due to the lack of empirical research. There are significant concerns relating to the medical effectiveness of medcaps.

- Agency. Subcontracting through NGOs appears to have many advantages in terms of rapidly extending the scale and reach of health provision. However, the impact on government legitimacy has not been systematically captured within the peer reviewed literature.

Prevention of conflict or reduction of violence during conflict

Epidemiological studies of conflict have undoubtedly led to changes in foreign policy and shifts in donor political and financial resources – particularly humanitarian assistance, conflict prevention work, peacemaking interventions, post conflict peacebuilding and restorative justice (through criminal cases brought before international tribunals and the International Criminal Court (Bedoya, 2007, Dfundheller; Simmons; Tam et al, 2004)). Thieren argues that ‘despite the difficulties of collecting data in disaster areas, the emerging practice of conflict epidemiology offers effective measurement methods that can generate reliable numbers to guide strategic decisions and influence political leaders (Thieren, 2005). Quoting work by Biljeveld (Biljeveld, 2008) and Tame et al (Tame et al, 2004) he goes on to describe how, in 2004 Physicians for Human Rights ‘conducted health and examination interviews among Sudanese refugees from Darfur in Chad. These experts established patterns of events tantamount to war crimes, and the interviews marked the first time epidemiology was used to “diagnose genocide”.’ He argues that this placed pressure on the United States to change its policies towards the Sudanese Government. However, he also recognises the limits of such studies, drawing attention to several epidemiological studies following the 2003 invasion of Iraq.
Arguably epidemiological surveys have the potential to be powerful instruments in support of advocacy strategies although they are clearly not panaceas and can be trumped by national interests. Also their impact on communities within the fragile states is unclear. Whilst it is reasonable to presume such surveys could mobilise community groups around particular issues there appears to be no proof within the peer reviewed literature that this social capital can serve as a bulwark against conflict drivers. Consequently this study has been unable to identify any systematic research that is able to demonstrate this and, indeed, methodologically this would prove extremely challenging for researchers operating in conflict environments.

**Peacemaking in conflict**

The concept of negotiated humanitarian access is the cornerstone of traditional humanitarianism and there is considerable evidence that health interventions have been a mainstay of this approach whilst also making considerable contributions to the reduction in mortality and morbidity rates (WHO 2006). For example, in 1985, the United Nations Children's Fund, the Pan American Health Organization and other partners worked in El Salvador for nearly 6 months in order to organise a temporary cease fire between warring factions. These 'days of tranquillity' resulted in some 20,000 people, including government and guerrilla health workers, providing vaccinations to over 400,000 children. WHO itself documents the use of health ceasefire in 19 states (Afghanistan, Angola, Bosnia, Chechnya/Russia, Democratic Republic of the Congo, El Salvador, Guinea-Bissau, Indonesia, Iraq, Lebanon, Mozambique, Philippines, Dominican Republic, Sierra Leone, Somalia, Sri Lanka, Sudan, Tajikistan, and Uganda) (see table below) and suggests another 22 examples based on more limited evidence (See annex A).

Whilst there is credible evidence that immunisation campaigns and the temporary cessation of overt hostilities have saved lives it is not clear from the literature the conditions under which health interventions can facilitate these types of ceasefires or whether health cooperation itself was a causal factor in the ceasefire or a symptom.
of something else – perhaps an improved relationship, political manoeuvring, external political pressure, the end of the fighting season, both parties seeking a breathing space in which they could reorganise and rearm militarily, etc. This study has been unable to identify systematic evidence that the health interventions were significant factors in creating conditions under which conflict could be resolved (as opposed to temporarily mitigated). Furthermore the grey literature appears to have distorted the debate somewhat – demonstrating both an almost ideological advocacy for the concept of health as a bridge for peace and a strong selection bias in favour of the more positive examples. These negotiated access agreements could more profitably be viewed as examples of negotiated humanitarian space rather than as preludes to broader peace processes. This finding was paralleled by Colin McInnes et al who concluded that:

‘the evidentiary base appears slim and overly reliant on anecdotal evidence rather than rigorous and systematic empirical work. Moreover, there has been little conceptual work done on key questions including: what works and why? What conditions are susceptible to such an approach? What level and form of health investment is required? When might it backfire and allow a conflict to continue? Can it be used to assist in ending conflicts, or just in post-conflict reconstruction? And can it be used to prevent conflict?’ (McInnes et al, 2006).

Rubinstein also echoed these findings in his analysis of US military ‘health diplomacy’ which he describes as ‘health interventions as a means of achieving strategic objectives in stabilisation contexts such as Afghanistan and Iraq, while at the same time aiming for a positive impact on the health sector as a whole.’ He concludes that ‘there is little evidence to suggest that even major improvements in health services delivery have proved a singularly important factor in the consolidation of the peace process or in the successful passage from transitional government to a more stable political environment. This may be because, as other experts suggest, the legitimacy of the state depends on much more than the delivery of services and that stabilisation, therefore, requires a more multi-pronged and multi-layered approach.’ (Rubinstein 2009)
Michael Thieren, drawing on work by Hess and Pfeiffer (Hess & Pfeiffer, 1999) is similarly sceptical of the role of HBP in kick-starting broader peace processes suggesting that ‘as it has been implemented in Angola, Bosnia, eastern Slavonia (Croatia) and Haiti, the project has never yielded a tangible peace dividend.’ Whilst this perhaps confuses the concept of a peace dividend (traditionally seen as a benefit from a newly established peace) with the idea that limited co-operation over health issues may lead to broader patterns of cooperation between belligerents, it is difficult to find any evidence that credibly portrays health cooperation as the principal driver or initiator of a peace process. Nevertheless, reflecting Zwi’s (Zwi, 1999) conclusions Thieren suggests that ‘at most, health professionals were able to create structures, systems of behaviour, institutions and collective actions that were amenable to a culture of peace, once political arrangements and agreements were otherwise secured.’

Whilst we have been unable to find systematic evidence of humanitarian access negotiations driving subsequent peace negotiations there are risks in instrumentalising health interventions in this way. The grey literature and interviews with members of the humanitarian community warn against humanitarian assistance being instrumentalised for politico-strategic ends. There was also concern that access negotiations could be hijacked by belligerents – introducing conditionalities or distortions that have the potential to undermine health outcomes. Furthermore, it is not clear from interviews that medical staffs are particularly well equipped/organised or sufficiently experienced to utilise access negotiations for more overtly political purposes and without an evidential base making clear the potential benefits and costs this approach clearly entails risks.

The absence of compelling research demonstrating that health interventions are able to deliver broader stabilisation effects makes the active pursuit of HBP a potentially risky instrument for stabilisation. Nevertheless this does not mean that negotiated access is not worthwhile from a purely health perspective.
Peacebuilding after conflict

In the context of a peace agreement there is evidence of health interventions making some positive contributions. The three principal theories of change in this area are:

- that public service provision enhances government performance legitimacy and perceptions of responsiveness thereby reducing societal propensity towards conflict;

- that carefully targeted health interventions help to undercut grievances based on a group’s (ethnic, religious or tribal) belief that government service provision in inequitable;

- that health issues can be a vanguard of reintegration and demobilisation processes and that cooperative processes in health are a useful entry point for stimulating broader co-operation.

**Performance Legitimacy**

The question of government legitimacy being approached through health is a reoccurring theme – with health interventions generally being portrayed as a central component of government performance legitimacy. In these models the social contract between the state and the population is characterised as being essential to the legitimacy and stability of a government and health provision is portrayed as a key lever in this process – although evidence of its effectiveness is far less forthcoming.

The peer reviewed and grey literatures appear to be very supportive of this approach. Waldman (Waldman, 2007), for example, asserts that a functioning health system can “contribute to an improved perception of government” whilst the Human Security Report, an influential, credible but not peer reviewed publication argued that the ‘reliable provision of accessible health care is a critical determinant of performance legitimacy, even in poor countries where health services are often minimal. In 2007, for example, a survey of African nations by Afrobarometer found that respondents’ satisfaction with their government was associated with their
satisfaction with the delivery of social services such as health and education, as well as its political and economic performance. Factors influencing satisfaction with health care were, in order of importance: perceived ease of access, the respondent’s level of poverty, perceived absence of corruption, and affordable fees for medical treatment.’ Darcy and Pavanello in their review of the service delivery literature argue that state legitimacy depends on responding to citizen expectations – and as such is inherently fungible. They quote the National Democratic Institute 2005’s survey of Northern Sudanese citizens who ‘ranked health care, education, employment (urban areas), and agriculture (rural areas) as post-conflict priorities for government attention. Interestingly, even in conflict areas, these concerns outranked settling ethnic conflicts and security issues.’ Similarly, Gordon & Wilder (Gordon & Wilder, 2010) in their 2007 study of Afghan governmental legitimacy in Helmand, Afghanistan identified health care provision as a significant priority amongst the populations of 6 Helmandi districts – and one that tended to eclipse long standing and bitter inter and intra tribal disputes (see table below).

| Helmand: Priority issues (from Gordon & Wilder, 2010) |
|-------------|-----------|---------|-----------|-----------|-----------|
|             | 1st       | 2nd     | 3rd       | 4th       | 5th       |
| Nad-e Ali   | Taliban   | Security | Healthcare | Reconstruction | Agriculture |
| Lashkargar  | Security   | Reconstruction | Healthcare | Talban | Government |
| Nawa        | Taliban   | Security | Agriculture | Healthcare | Women’s rights |
| Kajaki      | Taliban   | Healthcare | Reconstruction | Agriculture | Security |
| Sangin      | Taliban   | Healthcare | Reconstruction | Agriculture | Tribal tensions |
| Gereshkh    | Security   | Reconstruction | Taliban | Tribal tensions/ growing poppy | Healthcare |

Finally Jones (Jones, 2006) argues that his comparative historical research into the role of health in reconstructing states has shown that health can have an "independent impact" on wider nation building whilst also being impacted on by other key sectors such as security, education, governance etc. Jones concluded that
effective delivery of health services was a significant factor in enhancing the legitimacy of governments in post conflict contexts. This study drew comparisons between the restoration of health services in Germany and Japan after World War II, and in Somalia, Haiti, Kosovo, Iraq, and Afghanistan and he cites 'several cases [that] show that health can have a significant impact on security by helping to win hearts and minds.' However, the study lacked data on proxies for state legitimacy and, in this regard, relied heavily on anecdotal information.

The empirical evidence in support of all of these assertions is generally thin although there is strong consensus on the need for civil society to be involved in planning and monitoring performance in local health services and capacity building. Nevertheless there are no rigorous studies that can demonstrate empirically that increasingly positive attitudes towards government result from improvements in health service provision. Furthermore, it is unlikely that health care provision or any form of humanitarian action will be able to address and mitigate the types (and scale of) drivers of conflict in places such as Sudan, DRC or Afghanistan.\(^5\) Equally, evidence such as that provided by Gordon & Wilder (2010) and Zurcher at al (2009) suggest that in the context of Afghanistan the provision of security, justice, economic opportunities and the removal of corrupt government are more significant factors in increasing a government’s popularity than health service provision. Similarly in the absence of peace, and given the high levels of Taliban intimidation, the provision of public services has gained little or no traction as a popularity measure for the Karzai government in Afghanistan. Lastly, the time taken to strengthen the health care system in environments such as Afghanistan suggest that HSS has limited value as an instrument of political or military stabilisation where the time frames tend to be immediate.

\(^5\) In Afghanistan’s Helmand Province, for example, the post Taliban political settlement effectively installed feudal robber barons in powerful Provincial governmental positions. With the roots of their power in the remains of the fragmented tribal system, fuelled by the profits from the narcotics trade and the distribution of governmental patronage, health programmes were never seriously likely to mitigate this. This only began to change in 2006 with the appointment of Governor Daoud.
In part the lack of evidence reflects our limited understanding of the way in which state legitimacy is constructed and the role it plays in the consolidation of state stability. Legitimacy tends to be defined by the literature in terms of perceptions of the state’s responsiveness to its population – i.e. as a series of transactions between civil-society and the state in which elements of civil society formulate demands on the state and the state visibly responds (DFID, 2009). However, the literature lacks processes and indicators for tracking citizen ‘voice’ and government ‘accountability’ and their interaction (DFID 2009). The literature’s failure to objectively measure and evaluate these relationships and the underlying processes has also limited our understanding of the role and impact of NGOs and other agents of civil society in fostering the development of voice and accountability.

Legitimacy may also be defined in other ways, such as the restoration of a particular set of public services that were provided prior to a conflict. Pavignani and Colombo (Pavignani and Colombo 2001) for example suggest that this had a significant role in signalling the return to normality in Mozambique and Timor Leste, potentially creating a sense of a return to a more stable era. However, this model clearly requires an expectation of a particular role for government and a return to a specific model of service delivery and is of little value in situations, such as Afghanistan, where experience of government can be limited and attitudes towards it tend to be very negative.

Some authors (Waldman, 2007) argue that it is important to establish “legitimacy first”, through signalling ‘intent’- leaving the effectiveness of the health provision and developing community ‘voice’ and ‘government’ accountability mechanisms for later. Instead the model presumes that visible signs of ‘good social intentions of new governments’ are essential and that highly visible buildings, facilities and programmes – although less effective on the population’s health confer legitimacy which can pave the way for better future provisions. This politicisation of the health agenda can therefore be seen as potentially damaging to the provision of health, where visible facilities and one off events such as vaccination days impact negatively on routine medical provision and maintenance. However, given the propensity of health donors and practitioners to support these interventions anyway it is difficult to establish whether this represents an additional distorting factor.
Whilst donors place great faith in the construction of state legitimacy through public service delivery this process is poorly understood. Furthermore, the concepts of citizen ‘voice’ and government ‘accountability’ as well as their relationship to ‘service delivery’ and ‘government legitimacy’ are not well described in the literature – seriously limiting understanding of the utility of service delivery as a stabilisation instrument.

**Undercutting Grievances**

State legitimacy may be created through more complex processes geared around removing factors that marginalise and exclude groups from state services and resource allocation processes. Rubinstein (Rubenstein, 2009) for example argues that ‘health services both reflect and influence how women and marginalized groups are treated in society, the organization and administration of services can potentially contribute to a society where rights and the rule of law gain greater respect and adherence. This is particularly important in societies where conflict has been fuelled by ethnic, religious, or racial tensions, which are often played out in the health system. Additionally, by adhering to principles of community and civil society participation and government accountability, health systems development can advance the broader goals for state legitimacy.’ Others also focus on the perceived role of health interventions in ameliorating or accentuating broader grievances. Bloom (Bloom, 2005) provides an example drawn from Kosovo where, despite the General Health Law defining equity ‘as one of the primary objectives of the health system, health service provision remained divided along ethnic lines because of continuing distrust between Albanian and Serb Kosovars (Bloom 2005).’ Bornemisza et al concluded ‘that ensuring that all groups are included in service delivery can enhance the accountability and legitimacy of the government both nationally and internationally.’ (Bornemisza et al, 2007). Again the idea that equity of access and the transparency of process builds legitimacy and undermines grievances is plausible but this study has been unable to identify strong evidence of this having a clear impact on consolidating a peace process.

Given the emphasis placed by the counter insurgency (COIN) and state building literatures (see chapter 2) on the inequitable provision of public services being a
source of grievance there is little evidence demonstrating the impact of conflict on health access equity and how this changes the relationships between governments and populations. What evidence there is tends to be anecdotal or intuitive and leads to the search for theoretical frameworks for conceptualising health inequities (e.g. Bournemisza et al, 2010). However, and notwithstanding its shortcomings the evidence suggests that conflict creates or exacerbates existing inequitable public service provision. Joanna Macrea for example, in her study of the Uganda conflict during the 1990s, drew attention to how the Acholi areas in the north suffered from less access to health resources as fear of tribal reprisals and insecurity undermined the willingness of non-Acholi health workers to move outside of areas such as the Acholiland capital of Gulu (Macrae interview). She also highlighted how health officials and practitioners tended not only to flee the country but also to migrate towards more stable urban areas within the state – a process similar to that which occurred in Afghanistan from 2001 – creating both a general drain on the health sectors’ human capital but also exacerbating rural-urban access inequities. (See also Roberts et al, 2009.)

Perhaps the best evidence of the creation of health access inequities is provided by Victora, Fenn, Bryce and Kirkwood’s 2005 study. This explored the impact of ‘child survival’ interventions with data drawn from Bangladesh, Benin, Brazil, Cambodia, Eritrea, Haiti, Malawi, Nepal and Nicaragua. The study concluded that conflict created marked inequities in health access amongst the populations studied – for example ‘in Cambodia, children from the least poor quintile were 2.1 times more likely than those from the poorest quintile to receive three or more interventions and 18.6 times more likely to receive six or more interventions.’ (Quoted in Bournemisza et al (2010)). Hence whilst these processes are known to exist their impact on state-society relations remains relatively uncharted.

Despite the challenges with the evidential base there have been some limited successes in establishing the visibility of healthcare programmes and accountability between sub national levels of government and the beneficiary population. The PATHS programme in Nigeria, whilst clearly not in the context of conflict, has been able to demonstrate some improvement in the perceptions of local government.
Allison (Allison, 2008) concludes that where local government was given incentives to respond to community demands, the experience of health provision was far more positive (for example in Kaduna district). In return this lead to an increase in the community’s trust in government whilst stimulating social participation in local political processes. However this literature is not peer reviewed and whilst the findings appear to be reasonable there are issues of author bias and a weak methodology (see also Anyebe, 2008; and Green, 2008).

Nevertheless, the sense that health care provision is a route to legitimacy is strongly implied in the actions of insurgent groups. For example the Human Security Report cites the case of Hezbollah, in southern Lebanon providing ‘generous health insurance and efficient, accessible, and reliable health services to the local Shia population. In 2005, for example, some 50 hospitals in the country were being run by the organization, which also provides life and disability insurance, as well as other social services. In the wake of the August 2006 war with Israel, Hezbollah’s rapid provision of health care and reconstruction aid appears to have only strengthened its legitimacy in the south.’ Whilst the literature is unable to provide empirical evidence of the strategy’s effectiveness clearly Hezbollah’s leadership view this as a mechanism for generating political support (D’arcy interview).

Reintegration of former belligerents
Finally, it is at least possible that health interventions may reinforce peace building and military demobilisation processes. Pavignani and Colombo (Pavignani and Colombo 2001) for example stress the role played by health practitioners in consolidating the peace in Mozambique whilst Rohland and Cliffe (2002) credit the interaction between Timor Leste’s health ministry leadership and political leaders on all sides as providing a significant impetus to the consolidation of the peace and reconstruction process. Thieren cites the role of the Pan American Health Organization (a World Health Organization regional office) in ‘reintegrating 15 000 demobilized combatants of the Farabundo Marti National Liberation Front into El Salvador’s national health system. The operation was a success: each former combatant was medically screened, all were given treatment when necessary, and re-entered civil society in good health.’ However, it would be difficult to quantify what impact this had on the overall peace process and how essential it was to
progress. Whilst all of these examples make credible cases for a health lens being applied to reintegration of former combatants the evidence is largely anecdotal. Nevertheless, in circumstances were a peace deal establishes a reintegrative and potentially cooperative process health may reinforce this and provide a degree of traction.

Despite this there are examples where health interventions have been unhelpful. Thieren’s excellent 2007 article draws attention to how health-related stigmas were used as a tactic to polarise views during a peace process. He states that in early 1996, shortly after the signing of the Dayton Agreement ‘ostensible concerns relating to HIV/AIDS were used by north-east Bosnian civil authorities to oppose NATO (North Atlantic Treaty Organization) military peacekeeping intervention.’ Again, it is not clear whether this tactic was particularly successful rather than just being of nuisance value.

Military Medical Diplomacy

There is a very limited literature describing the effectiveness of military ‘medcaps’ and the research team have been unable to find peer reviewed material that provides a systematic and non partisan evaluation. Similarly, in the course of several years of research in Afghanistan members of the team have been unable to identify the use of measures of effectiveness within the military that were able to gauge the impact of medcaps on ‘hearts and minds’, attitudes or the flow of militarily sensitive information.

Amongst military interviewees opportunities for interacting with the civilian population through health were considered to be important but medcaps enjoyed a mixed reputation. Christopher Bulstrode suggests that within the military medical profession ‘MEDCAPS are almost universally regarded as being good for relations between the military and civilians’ (Bulstrode, 2010) whilst Bricknell and Gadd (Bicknell and Gadd, 2009) argued that there were uniformly seen as ‘a legitimate instrument for such engagement.’ However, interviews with senior Army doctors suggested that there were some misgivings above their overall medical effectiveness
and concern as to whether they in fact routinely delivered against broader objectives.

Bulstrode argues against their medical value at length; suggesting that in reality the transient nature and limited or negligible medical impact of medcaps ‘can actually have a negative effect, contributing little in terms of relieving suffering, or improving relations between military and civilians’ and warning that there is ‘no evidence as [to] their actual efficacy in any objective terms. MEDCAPS are not without risks and have the potential to do harm as well as good.’ His principle criticisms derive from the impact of the security environment on patient access and the quality of the medical care provided. In order to limit opportunities for Taliban attacks or suicide bombings medcaps were generally organised at short notice and, in order to avoid setting a pattern that could be exploited by the Taliban, without follow up clinics. Similarly the clinics generally took place close to but outside of ISAF bases – limiting the opportunities for access of a widely dispersed, and largely rural potential patient population.

The security precautions not only distorted the location and timings of provision but also sometimes lead to Taliban threats against patients who used the military facilities and were seen as benefiting from ISAF support (Hamkins interview). The ad hoc nature of the clinics also impacted on the quality of the medical service provided. Bulstrode argues that military clinics lacked ‘adequate facilities (medicines, equipment etc) to diagnose, or manage, most conditions properly. It was also difficult to provide proper facilities, which gave patients adequate privacy. It was not possible to provide any investigations such as blood tests, ECG or Chest X-Rays.’ He also draws attention to a range military training and cross cultural awareness issues – arguing that the military were inadequately trained in the ‘prevalence, presentation, diagnosis and treatment of medical problems likely to be encountered amongst the local Afghan population. Diseases such as Cutaneous Leishmaniasis, malaria, tuberculosis and nutritional deficiency are common but difficult to diagnose and treat properly. Most of the conditions seen are also chronic and are either not easily treated (Leishmaniasis) or require long-term monitoring if treatment is to be successful (tuberculosis). These cannot be managed properly using MEDCAPS.’ Similarly military medical staff did not receive adequate training
in the ‘way in which people in different societies describe symptoms’ and that this was a particular barrier to understanding psychiatric illness.

In terms of the impact of medcaps on ‘hearts and minds’ Bulstrode raises a range of concerns – the risk of being seen to compete with and irritating local health practitioners, raising and failing to meet surprisingly demanding and sophisticated beneficiary expectations, the limited facilities and time available leading to errors in (or an inability to make a) diagnosis, poor quality treatment and a lack of follow up care leading to discontent. The inadequacies of the facilities also raised the potential of medical officers providing unethical treatments such as placebos in place of appropriate care. He also suggests that the Helmandi population were too sophisticated to accept these shortcomings.

Despite the strong drivers behind a military role in healthcare provision ISAF’s policy on MEDCAPS has fluctuated from active encouragement by senior commanders through to strong discouragement. There are also several policies restricting the military involvement in medcaps. Within Helmand the dominant framework is the Regional Commands directive limiting medcaps (HQ RC(S) SOP 9950, MEDCAP and Medical Engagements, dated 15 April 2009). Nevertheless, during the November 2009 visit the authors identified continuing pressure from middle ranking officers to engage in medcap programmes. The polarisation of views on the utility of medcaps suggests that it would be valuable for the SU and the Military Medical Services to agree framework issues note detailing a joint position on their role in stability operations.

**Agency and Public Service Provision**

The stabilisation literature appears to contain very little on the question of ‘agency’ and the relative benefits of sub contracting versus direct delivery of public services through host government. However, there is almost universal consensus amongst stabilisation practitioners that public service delivery through domestic structures and processes is preferable to the imposition of solutions by outside agencies.
The health literature’s treatment of ‘agency’ is far more sophisticated. The starting point is to characterise health systems both as complex social institutions and political constructs (Bloom, 2001; Bodenheimer, 2005; Freedman et al., 2005; Gilson, 2003; Kruk & Freedman, 2008; Shi, Starfield, Politzer, & Regan, 2002) - in effect describing them as interdependent systems involving state institutions, policy frameworks, civil society and an array of non state actors – NGOs and for profit organisations. This obviously generates considerable variation between systems - including differences in health infrastructure, the strength and content of regulatory frameworks, accountability and voice relationships, health challenges, capacity, perceptions of, numbers and mandates of actors and the social and political context of health and state building decisions. This makes very difficult the creation of a universal model through which a health intervention could strengthen the legitimacy of a state.

Furthermore the literature makes clear that health interventions are not necessarily structured with state building or non health stabilisation as a particular priority. Humanitarian health interventions are frequently characterised as providing structured vertical programmes such as child immunisation or feeding programmes plus specialised facilities such as emergency field hospitals (although others may pursue broader ranges of activities including mental and reproductive health, education, training and prevention strategies (Betsi et al., 2006; Pavignani & Colombo, 2005)). Laurence and Poole suggest that a typical typology is that of ‘donors funding NGOs to provide services, with the NGOs maintaining tightly vertical systems for monitoring and reporting on resources and financial management. A “patchwork” of operations driven by competing donor priorities, processes and reporting requirements – this is sometimes organised by allocating certain districts to certain funders and/or NGOs. (Laurence and Poole, 2005). Waddington et al elaborate on this suggesting that the topography includes:

• ‘Specific organisations contributing to particular programmes – immunisation, HIV and AIDS etc. WHO and UNICEF are often actively involved in immunisation programmes.
• Some technical support to the Ministry of Health.
Funding to rehabilitate the physical infrastructure of health facilities – the state involved to a greater or lesser extent in identifying priority facilities and contractors.’ (Eldon et al; 2009).

Notwithstanding differences in agency mandates and some NGO’s declaratory commitments to broad based and sustainable programmes some authors suggest that international responses are subject to a range of distortions. For example, rather than making equal progress along each of the strands of HSS proposed by the WHO, Eldon et al point to the way in which international NGOs may distort health programming priorities - tending to focus more on visible deliverables such as facilities, infrastructure and single issue vertical programmes and suggesting a relative neglect of the less visible support capacities such as procurement, health information and policy framework development that might strengthen the health system as a whole and lead to more sustainable outcomes Eldon et al; 2009). Distortions also derive from particular donor and recipient state preferences. The pressure to demonstrate ‘quick wins’ also has the potential to ‘lead development partners and governments to concentrate efforts on urban areas where there is some health infrastructure, leaving the rural areas without services.’ (Waters, Garrett, & Burnham, 2007). Similarly, Vergeer et al draw attention to preferences of health practitioners for life saving interventions rather than focusing on sustainability or capacity building (Vergeer et al., 2009).

International efforts are equally unpredictable – with overlapping programmes reducing overall effectiveness and creating inefficiencies (Bacchus, Mezey, & Bewley, 2004; Ball & Hendrickson, 2005) whilst tensions also emerge over the best ways of achieving quick results and how to balance these against building state capacity. Donors also frequently disagree on whether to strengthen weak governments and, if they should, how best to do this (Vergeer, Canavan, & Rothmann, 2009). Furthermore, Vergeer et al’s 2009 study suggested that the choice of health intervention coordination mechanisms employed by the international community has a significant impact on the process of rebuilding the health system as a whole (Kruc et al (2007).
The tension between trading off visible life saving ‘deliverables’ and the less visible ‘sustaining’ functions is also clear in the practitioner literature. In ‘Everybody’s Business’ (WHO 2007) the WHO suggest that ‘managing the tension between saving lives and livelihoods and starting the process of re-building the states is a particular challenge in fragile states.’ This dilemma can be seen most starkly in terms of the differing emphases (in different countries) placed on subcontracting service delivery through NGOs (versus delivery by government) and choices over the level at which government capacity building is supported (national, provincial or district). These dilemmas are particularly acute in post-conflict situations but given the scale of the problem there is surprisingly little empirical evidence about when and how to transition most effectively from immediate relief to HSS priorities in programming’ (Vergeer, Canavan, & Rothmann, 2009).

Despite this, authors such as Rubinstein argue compellingly that ‘over the last two decades, initiatives by donors, nongovernmental organizations (NGOs), public health experts, and states to build health systems in the aftermath of conflict have yielded a set of ideas and strategies that, when flexibly applied, can guide both the reconstruction process itself and the design of aid mechanisms and polices to support it. There exists a growing consensus that in many circumstances donors can best address the health crises stemming from war by moving as quickly as possible from providing emergency health services to supporting the capacity of the state’s ministry of health to plan, implement and oversee a comprehensive and transparent system of health services grounded in primary care. With such support, the ministry can and should develop and implements policies and plans to create a system of health care that includes elements such as disease surveillance, disease prevention (including vaccinations), health services, health information systems, supply chain management, human resources for health, and monitoring and evaluation.’

The academic and practitioner literature demonstrates a broad based consensus that improvements in HSS facilitate significant improvements in health outcomes. There is also considerable agreement on the requirement to devise a national policy framework for health interventions at the earliest possible opportunity (Carlson, Lamalle, Fustukian, Newell-Jones, Sibbons & Sondorp 2005 also Rubenstein, 2009)) with the alternative being a less satisfactory project based approach. Darcy et al
argue that experience suggests projectised approaches lead ‘to a fragmented and uncoordinated response that poorly addresses the institutional failures and governance deficits that are at the core of state fragility. The promotion of vertical, non-integrated programmes, such as the creation of multiple vertical or special programmes to address the same health issue, is increasingly perceived as creating mechanisms that bypass (rather than include) state institutions and systems’ (Darcy and Pavanello; PCRU QIPs Evaluation 2007). These risk undermining accountabilities and creating ‘new and often deeper institutional failures’ (Commins 2005, see also HLF 2005(a), Berry et al 2004, Newbrander 2007, OECD/OCDE 2006, OECD 2008, Meagher 2005).

Whilst it is fair to say that health interventions are not generally configured around building state legitimacy as a primary objective the health literature is much clearer on the benefits of relying upon sub contracted NGOs as implementing partners (particularly in difficult to reach or marginalised areas) (Cometto, 2006; also Roberts et al, 2008). In fragile state and conflict environments this may have benefits – enabling a rapid scaling up and geographical targeting of health service delivery (Strong et al, 2005.) whilst also establishing the government in the role of steward, managing and evaluating the performance of the implementing partners as well as ‘reviewing contract bids, evaluating NGO performance and establishing strategies, standards and regulations.’ (Roberts et al, 2008). Loevinsohn et al argue that its principal benefits are in terms of ‘effectiveness, efficiency and equity’ – potentially creating a cost effective strategy that is most able to reduce mortality and morbidity and address issues of equity (Loevinsohn & Harding, 2005; Newbrander et al, 2007). Similarly the creation of a strategic framework for donors appears to facilitate greater aid effectiveness and coherence in their efforts as well as a process for addressing issues of equity in medical access.

One way in which donors have sought to manage the overall coherence of their interventions and the transition from emergency relief to more sustainable forms of delivery is through agreeing on and implementing a Basic Package of Health Services (BPHS). Initially championed by the World Bank and piloted in Cambodia, the approach has also been attempted in Afghanistan, DRC, Southern Sudan, East Timor, Liberia and Somalia (Darcy and Pavanello, 2009). This approach involves
the beneficiary state government and donors agreeing a basic package of health services whilst delivery may be directly though government bodies or jointly through sub-contracting NGOs (or, as in the case of 4 of Afghanistan’s Provinces, government Provincial health offices – Fishstein interview) The balance between government and NGO delivery is usually context dependent but advocates of the later frequently point to the way in which this can enable a rapid scaling up of ‘cost effective’ and ‘efficient’ health services (Roberts et al, 2008). Such an approach has the potential to link projects designed to deliver quick impacts with longer term HSS objectives (Waldman 2006, OECD/OCDE 2006) but can also provide opportunities for ensuring the accountability of governments to their populations. Pavanello suggests that BPHS help to deliver a shared vision of priorities and a clear framework within which donors could support host governments (Pavanello, 2008) - specifying the ‘physical characteristics of health facilities, their distribution on a population basis, their staffing patterns, and their specific public health interventions’ (Waldman, 2007). They may also build governmental capacity to manage the performance of implementing NGOs and government offices – enabling the establishment of cost evaluation and performance indicators and enabling a degree of community participation in making health providers accountable.

BPHSs and widespread NGO subcontracting of their delivery are a relatively new innovation and there appears to be very limited peer reviewed evidence on their broader effectiveness, particularly in terms of their impact on government legitimacy and the trade off’s inherent in the reduced role for government in delivery (despite the balanced scorecard evaluations – see Peters et al, 2007). In the case of Afghanistan the evidence from the Government does point to a rapid scaling up of delivery with the Ministry of Public Health’s (MOPH) Grants and Management Unit concluding that by early 2005, 2 years after its inception, the BPHS had extended health care to 77% of the population - particularly impressive in the face of a large influx of returning refugees and IDPs and perceived as necessary to deliver a peace dividend (Lancet Editorial, 2005). In November 2009, Amin Fatimie, Minister of Public Health of Afghanistan announced that the MOPH had ‘outsourced 40 national and international NGOs to deliver BPHS services to 31 provinces of Afghanistan. In the remaining 3 provinces, BPHS is delivered by MoPH through Strengthening Mechanism. BPHS has covered around 85% of Afghanistan rural areas’ (Afghan
MOPH, 2009). Furthermore the balanced scorecard review of the BPHS, whilst generally very positive, tended to address issues unrelated to government legitimacy.

Others warn that it is not a panacea. Research in the south and north east of Afghanistan (Gordon & Wilder, 2009 and Zurcher et al, 2008) suggested that insecurity remained the dominant concern of the Afghan population and the extension of health provision and other public services had been insufficient to build government legitimacy outside of the provincial capitals. Equally the BPHS does not automatically resolve ‘what exactly should be included in the package, who is setting the agenda, how to cater for health problems that fall outside the package’ (LSHTM 2007 and Odaga 2004). Equally Paul Fishstein of the Carr Centre warned that public service delivery and the creation of beneficiary ‘voice’ has the capacity to raise expectations faster than government’s service delivery capacity or willingness to be accountable (Fishstein interview) – potentially working against the growth of performance legitimacy.

Furthermore, whilst some might suggest that sub contracting NGOs is an interim measure pending the growth in government capacity Palmer et al warn of the potential for this to become a permanent feature of service provision (Palmer et al, 2005.) and concludes that limiting the role of the government to that of ‘decision maker’ rather than ‘deliverer’ potentially reduces the capacity of the government to generate legitimacy through service delivery and may not have a particularly strong role in strengthening government – however, this has not been systematically measured nor is it entirely clear how it would be.

Hence, whilst there is agreement that widespread sub contracting of the BPHS’s delivery offers many potential benefits, there are clear challenges. In particular the impact on state building and the process of building government legitimacy is not well understood.
Findings

- In terms of the evidence base for health having a role in preventing conflict or reducing levels of violence during conflict it is possible to conclude that:
  - Epidemiological studies clearly can influence international responses to conflict but the peer reviewed literature is imprecise on the role and effectiveness of such studies in shaping responses.
  - Evidence on their impact within conflict states has not been collected systematically.

- In terms of the evidence base for health having a role in peacemaking (during conflict) the evidence is mixed. There is strong evidence in support of humanitarian cease fires based around health access leading to significant reductions in M&M rates in several conflicts. However, these tend to be examples of ‘humanitarian space’ rather than broader peace processes and many appear to rely on the sense that health interventions are discrete and limited interventions. The literature has been unable to demonstrate that health based access agreements have been responsible for or are significant factors in initiating broader peace processes.

- In terms of the evidence base for health having a role in peacebuilding after conflict the evidence is, once again mixed. The peer reviewed literature does not appear to provide systematic analyses of the extent to which health system strengthening contributes to broader processes of state building and peace consolidation. The evidence base is credible in theory but is generally anecdotal, shaped by author bias and has not been subject to systematic research. Similarly there is little clear evidence of the impact on governmental legitimacy of the interaction between health system strengthening, the generation of community ‘voice’ and government ‘accountability’. These are clearly priorities for further empirical research.

- The literature review provided no credible evidence that military health ‘hearts and minds’ interventions have a positive impact on beneficiary community
attitudes. In part this is due to the lack of empirical research. There are significant concerns relating to the medical effectiveness of medcaps.

<table>
<thead>
<tr>
<th>Evidence Issues</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes</td>
<td>Evidence for improvements or decline in health outcomes generally strong. Outputs are easily defined and generally less abstract than in other areas. Monitoring processes tend to exist and are widely understood and accepted.</td>
</tr>
<tr>
<td>Stabilisation outcomes</td>
<td>Generally weak. Outputs and outcomes generally very difficult to measure due to the conflict environment, political context and abstract nature of issues such as legitimacy, voice, government responsiveness and social cohesion. Diversion of resources from monitoring to delivery weakens collection of data.</td>
</tr>
<tr>
<td>COIN outcomes</td>
<td>Generally very weak. No culture of critical evaluation and few systems in place. Operational analysis systems focus on kinetic measures and tactics rather than ‘influence’. Sensitivity of findings precludes review and publication.</td>
</tr>
<tr>
<td>Statebuilding outcomes</td>
<td>Generally strong in terms of institution building but much weaker in terms of analysis of capacity building, the role of civil society and functioning of accountability mechanisms.</td>
</tr>
<tr>
<td>Peacebuilding outcomes</td>
<td>Generally weak. Lack of systematic and rigorous monitoring and biases in reporting.</td>
</tr>
</tbody>
</table>
Chapter Four: General Conclusions

- In terms of the impact of conflict on health and health systems there is consensus within the literature that ‘indirect deaths’ resulting from conflict situations increase dramatically due to the disruption of access to and the strength of health services in affected countries and through increasing vulnerability to disease vectors. In part this explains the necessity for holistic approaches to health system strengthening and the greater emphasis placed on managing a rapid transition from emergency based interventions to more developmental approaches. This also explains the emphasis in the peer reviewed literature and amongst donors on facilitating ‘stewardship’.

- The role of health interventions in stabilisation programmes remains ill defined and the peer reviewed literature largely fails to demonstrate empirically health’s contribution to these expanded objectives of health interventions.

- There appear to be very few health programmes that systematically address explicit stewardship, stabilisation or statebuilding outcomes within their programme design – with the limited range of examples including the BPHS concept, Partnerships for Transforming Health Systems (PATHS) in Nigeria and the Reproductive and Child Health Care Programme Plan in Sierra Leone. Perhaps surprisingly, the ISAF health programme in Helmand, Afghanistan and the ONUC health support plans in the eastern Congo appear to have little or no direct role in terms of stabilisation and wider state building outcomes.

- There is limited anecdotal evidence that health can mitigate state fragility, contribute to state-building, and in certain situations has been a factor in consolidating peace building processes. However, the evidence is not collected systematically and there are significant gaps in theorising and the development of proxy or direct indicators that can be monitored in conflict or fragile state environments. The absence of routine monitoring and evaluation of health’s superordinate objectives as well as a paucity of clear and measurable indicators
of progress limits the peer reviewed literatures ability to furnish empirically sound answers to these questions and there remain considerable gaps in the knowledge base. Furthermore, there is a strong tendency to view statebuilding as a linear and apolitical process and to neglect the complexity and situationally specific nature of ‘legitimacy.’

- The limited review of programme documentation highlighted the elusive nature of health governance and capacity indicators and a requirement to develop clear and measurable indicators of progress in the areas of the ‘superordinate goals’ and the general lack of investment in systematic M&E in these areas of health programmes. Whilst the evidence of health’s contribution to peace building remains elusive it is widely agreed in the literature however that health planning should continue to reflect that, whilst peace building can be a welcome ‘secondary consequence’ the primary objective of health provision should be health outcomes.
# Annex A

## LIST OF COUNTRIES WITH DOCUMENTED HUMANITARIAN CEASE-FIRES


<table>
<thead>
<tr>
<th>Country</th>
<th>Date</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>16-19 Apr. 2001</td>
<td>The second of five three-day rounds of Polio NIDs to be held this year (next one planned in May) began after Afghanistan's ruling Taliban Islamic Movement and the opposition Northern Alliance agreed to a week-long cease-fire, with particular emphasis on internally displaced children in all Afghan districts that border Pakistan.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>13-19 Mar. 2001</td>
<td>The Taliban and Northern Alliance agreed to respect a HCF following a request by UNICEF and WHO, in order to allow the immunization campaign.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2000</td>
<td>Limited agreed cease-fires for Polio NIDs (May/June, 14-16 Oct.-13-15 Nov.), added to social mobilization activities and the adoption of a house-to-house strategy, contributed to a higher vaccination, with almost six million Afghan children having been successfully immunized.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1997</td>
<td>Limited agreed cease-fire for Polio NIDs.</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1996</td>
<td>The 1996 Atlanta Olympics inspired UNICEF-brokered a six Days of Tranquility (3/5 million children were vaccinated, during Polio MICs), with the support of WHO.</td>
</tr>
<tr>
<td>Angola</td>
<td>1999</td>
<td>Days of Tranquility, with three millions children immunised during Polio NIDs.</td>
</tr>
<tr>
<td>Angola</td>
<td>1996</td>
<td>Renewal of conflict.</td>
</tr>
<tr>
<td>Angola</td>
<td>1995</td>
<td>Locally arranged Days of Tranquility in Northwest region for immunisation program. No published record.</td>
</tr>
<tr>
<td>Bosnia</td>
<td>20 Nov. 1994</td>
<td>Lusaka Peace Protocol, including humanitarian provisions.</td>
</tr>
<tr>
<td>Bosnia</td>
<td>1995</td>
<td>Cease-fire and Dayton Peace Agreement.</td>
</tr>
<tr>
<td>Bosnia</td>
<td>1994</td>
<td>Forced ‘Corridors of Peace’: UN humanitarian assistance combined with military intervention by NATO.</td>
</tr>
<tr>
<td>Chechnya/ Russia</td>
<td>2000</td>
<td>MSF gained access to Grozny for humanitarian activities. In 2001 MSF suspended its operations for security reasons, after one of their workers was captured.</td>
</tr>
<tr>
<td>Chechnya/ Russia</td>
<td>13 Aug. 1996</td>
<td>Agreed cease-fire, valid not only for Grozni but also for Gudermês and Argún, includes the exchange of prisoners and dead and the opening of a humanitarian corridor for the assistance to civilian victims.</td>
</tr>
<tr>
<td>Democratic Rep. of Congo (DRC)</td>
<td>17-20 August 1999</td>
<td>Three Days of Tranquility for Polio NIDs, after joint appeal of WHO-UNICEF to UN SG. They reached an estimated 80% of the approximately 10 million children.</td>
</tr>
<tr>
<td>Democratic Rep. of Congo (DRC)</td>
<td>7 July 1999</td>
<td>Lusaka (Zambia) Peace Accord signed, broken later on. Establishment of ‘Humanitarian Corridors’ for ‘the provision of urgent humanitarian assistance’.</td>
</tr>
<tr>
<td>Democratic Rep. of Congo (DRC)</td>
<td>Nov. 1996</td>
<td>Temporary HCF. Polio eradication activities, NIDs (since 1998) and SNIDs</td>
</tr>
<tr>
<td>Region</td>
<td>Year</td>
<td>Event Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>El Salvador</td>
<td>1991</td>
<td>Days of Tranquility (formal truces): as many as 20,000 health workers got 250,000 children immunised against polio, measles, diphtheria, whooping cough, tetanus and other diseases. Food and essential medicines were delivered to civilian populations threatened by famine or 'food blockade'. Process generally facilitated by ICRC and the Catholic Church, with the support of Rotary Club, UNICEF and PAHO/WHO.</td>
</tr>
<tr>
<td></td>
<td>1990</td>
<td>Days of Tranquillity.</td>
</tr>
<tr>
<td></td>
<td>1989</td>
<td>Days of Tranquillity.</td>
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<tr>
<td></td>
<td>1988</td>
<td>Days of Tranquillity.</td>
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<td></td>
<td>1987</td>
<td>Days of Tranquillity.</td>
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<tr>
<td></td>
<td>1986</td>
<td>Days of Tranquillity.</td>
</tr>
<tr>
<td></td>
<td>Spring 1985</td>
<td>First registered case of Days of Tranquillity for immunisation purposes.</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>26 Aug 1998</td>
<td>HCF agreement for 'the provision of humanitarian aid and the logistical support to the cease-fire observation mission and the return of refugees and displaced persons'. Polio NIDs. Cease-fires broken into new conflict.</td>
</tr>
<tr>
<td>Indonesia/ACEH</td>
<td>Jan 2001</td>
<td>Agreed ‘moratorium on violence’. Unstable situation.</td>
</tr>
<tr>
<td></td>
<td>2 June 2000</td>
<td>‘Humanitarian pause’ for humanitarian and political reasons. Originally signed in May for a 3-month period, then extended until 15 January 2001. Partially ignored (more than 500 violent deaths).</td>
</tr>
<tr>
<td>Iraq</td>
<td>1998-</td>
<td>Polio NIDs and SNIDs.</td>
</tr>
<tr>
<td></td>
<td>1996</td>
<td>The 1996 Atlanta Olympics inspired UNICEF-brokered truces between warring factions in Kurdish areas of Iraq for immunisation campaigns (66,000 vaccinated).</td>
</tr>
<tr>
<td></td>
<td>Jan. 1991</td>
<td>Corridors of peace to allow truck shipments of medicines for children. An important role in that was played by WCRP, which, in co-operation with UNICEF, invited the world's religious communities to write to the UN urging humanitarian aid to children and non-combatants.</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1987</td>
<td>Days of Tranquillity: Polio NIDs, brokered by UNICEF, along with the opening of &quot;Corridors of Peace&quot; to provide vaccines and other assistance.</td>
</tr>
<tr>
<td>Philippines</td>
<td>1995</td>
<td>Polio NIDs.</td>
</tr>
<tr>
<td></td>
<td>1994</td>
<td>Agreed cease-fires for Polio NIDs, considered as important steps on the road to a permanent solution of the conflict.</td>
</tr>
<tr>
<td></td>
<td>1993</td>
<td>Community-based &quot;zones of peace, freedom and neutrality&quot;, including respecting a cease-fire within a certain geographic area, no military encampments nearby, no intimidation or harassment, no public display of firearms except by police, strict enforcement of a firearms ban for off-duty personnel, dismantling of private armies and paramilitary forces, prohibition of death squads or vigilante groups, safe passage and sanctuary for the wounded and pluralism of political parties and ideologies.</td>
</tr>
<tr>
<td>Santo Domingo</td>
<td>1965</td>
<td>Joint efforts of ICRC, local Red Cross, UN and OAS succeeded in halting the fighting for 24 hours in order to collect the wounded; during that time negotiations were held that put a final end to the armed clashes.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>March 2001</td>
<td>Planned SNIDs in RUF-controlled Area. Cooperation amongst UNICEF, WHO, USAID and Rotary International in negotiating with RUF.</td>
</tr>
<tr>
<td></td>
<td>10 Nov 2000</td>
<td>30-day cease-fire, agreed in Abuja (Nigeria), with 'unimpeded movement of humanitarian workers'. ECOWAS-sponsored synchronised Polio NIDs in the whole country and in Liberia.</td>
</tr>
<tr>
<td></td>
<td>July 1999</td>
<td>Lomé (Togo) Peace Agreement: Polio immunisation campaign (NIDs).</td>
</tr>
<tr>
<td></td>
<td>24 May 1999</td>
<td>Agreed cease-fire in order to 'guarantee safe and unhindered access by humanitarian organizations to all people in need; establish safe corridors for the provision of food and medical supplies to ECOMOG soldiers behind RUF lines, and to RUF combatants behind ECOMOG lines'.</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>Separated (in Government and RUF-controlled areas) Polio SNIDs, ‘disrupted’ by war.</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Ongoing activities aimed at facilitating a HCF. Role of OCHA, Ambassador Tom Vraalsen (UNSG’s Special Envoy for Humanitarian Affairs in Sudan and Norwegian Ambassador to the United States), IGAD Partners Forum. CAP launched by OCHA. Planned NIDs in April.</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>Agreed period of tranquillity in Southern Sudan (facilitated by UNICEF), broken by both parties (with mutual accusations). Polio NIDs.</td>
<td></td>
</tr>
</tbody>
</table>
| 1999 | -(15 July) The Government decides not to extend the HCF but calls the SPLA for a general and comprehensive cease-fire in the whole country in order to ‘facilitate peace negotiations’. SPLA doesn’t accept.  
- The Sudanese government appears to have taken advantage of the three month humanitarian cease-fire organized under the auspices of the East African regional group IGAD to rearm using oil revenues.  
- Separated unilateral cease-fires, by both sides.  
- System of ‘quick cooling’ and immediate transport for vaccines. Training programmes on immunisations for more than 5,000 Sudanese. Use of oral vaccines.  
- Polio SNIDs, through house-to-house strategy, hindered by lack of security. |
| April 1997 | Khartoum Peace Agreement between the Government and the South Sudan Independence Army (which broke away from the SPLA in 1991). |
| 1996 | Safe access for humanitarian agencies. |
| 1995 | Ex-President Carter brokered the “Guinea worm cease-fire”, which lasted almost six months, and brought health workers to more than 2,250 Guinea worm endemic villages. |
| 1994 | Safe access for humanitarian agencies. |
| 1989 | “Operation Lifeline Sudan” (OLS) (UN-led consortium of relief organizations both international and national, governmental and non-governmental) started: arrangements were made for eight “corridors of peace” so that relief supplies and vaccines could be delivered during relative lulls in the conflict. No real cease-fire, only ‘relief corridors’ for food, immunisation and drugs. |
| Sep-Oct 1999 | Days of Tranquility for children immunisation. In the Batticaloa District the process of organizing those Days in the war zone cultivated important informal channels of communication and co-operation across political and ethnic divides. These channels have been central to the negotiations, which finally brought electricity back to the region. |
| 1997 | Formal truce for polio eradication. |
| 1996 | Agreed suspension of hostilities for NIDs. |
| 1995 | Agreed suspension of hostilities for Polio NIDs. |
| Tajikistan | 1997 | Peace Accord |
| 1995 | Formal truces for polio eradication (according to BMJ). |
| Uganda | 1986 | Corridor of peace, facilitated by UNICEF and Red Cross, to transport food and medicine to civilian populations threatened by famine or “food blockade”. Air bridge from Kampala to Kasese. |
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19. Geoff Loane (ICRC)
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21. Anu (UK Helmand PRT)
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