

## Helpdesk Research Report: Service Delivery and Stabilisation

Date: 06.02.09

**Query:** Please identify literature on the role of service delivery (health, education, water) in stabilisation environments. Has 'stabilisation service delivery' resulted in communities buying into the 'new' political settlement'? Are there examples of 'stabilisation' Service Delivery that have been institutionally sustainable (i.e. is there a 'double-win', where the intervention worked for the hearts and minds agenda and also aided institution building)?

**Enquirer:** DFID Politics and States Team

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### 1. Overview

There is very little evidence on the impact of stabilisation service delivery initiatives on producing a peace dividend, or providing the basis for longer-term sustainable reform. This may be because of the small number of available cases, and the limited availability of quantitative and qualitative information, as well as the difficulties of data collection in post-conflict environments.

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 points for wider peace-building processes. Health interventions can also play a key role by:

- *Offering tangible benefits:* These include health programmes for the local population and meeting basic health needs, such as improving sanitation and nutrition conditions. The rebuilding of destroyed facilities and reliable supply of those facilities with motivated personnel and appropriate medicines can also contribute to an improved perception of government.
- *Constituting a super-ordinate goal:* Health goals transcend the separate goals of parties to a conflict and can best be achieved when the parties join efforts. Health interventions may also offer a model for collaborations with various sectors of society, including state ministries, public, private, and traditional services, non-governmental organisations, civil society and the international community.
- *Evoking altruism:* Health care is an institutionalised expression of human altruism.
- *Healing trauma:* Health care professionals can utilise methods of trauma-healing that are linked to social processes of reconciliation and peace building.
- *Contributing to civic identity:* In cases where societies have been divided by identity conflicts, people who have an adequate and equitable health care system are

strengthened in their sense of belonging to the society or the state that has provided it for them.

- *Contributing to human security:* An adequate and equitable health care system, which addresses people's basic needs, gives them an essential form of security.

Certainly, American military experts often use the term 'health diplomacy' when talking about 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. However, various commentators argue 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.

In stabilisation contexts, a particular challenge is how, given that the state often lacks the capacity to ensure reliable services, provision by external actors and donors can enhance state legitimacy and not weaken it. In such a case, ensuring that the state's role in service delivery is clearly communicated is key. Irrespective of the state's capacity, public information should seek to maximise the state's association with programmes, e.g. social funds. If grants are seen as coming from the state, this can help enhance its legitimacy.

The long-term commitment of donors is also important. National governments will never reach the point at which sustainability is a real possibility if donors withdraw too early, i.e. without developing technically and administratively trained staff.

The transitioning from humanitarian interventions to longer-term development programmes is an important element of this query. This has significant implications for financing, programming, accountability and capacity building, and there is a vast literature on these issues. While addressing them in detail remains outside of the scope of this helpdesk report, some of the key recommendations for donors include:

- Ensuring that partner country governments are active participants in planning and programme development;
- Identifying and capitalising on existing sources of capacity (even if very small; also, these may be at the community level, not the centre) and political will as starting points for service delivery system rehabilitation;
- Create incentives for international NGOs and firms to transition from directly providing service-delivery operations to building local capacity and engaging with public health system actors;
- Promoting investment in local community organisations, bearing in mind issues of exclusion and capture at the local level; and
- Considering how relief activities can be structured not as stand-alone efforts, but as integral components of an eventual hand-off to country actors.

## 2. Service Delivery in Post-Conflict Contexts

**Zwi, A., 2004, 'Health and Peacebuilding: Securing the Future', University of New South Wales**

[http://www.sphcm.med.unsw.edu.au/SPHCMWeb.nsf/resources/AUSCAN\\_Issue\\_Paper\\_1.pdf/\\$file/AUSCAN\\_Issue\\_Paper\\_1.pdf](http://www.sphcm.med.unsw.edu.au/SPHCMWeb.nsf/resources/AUSCAN_Issue_Paper_1.pdf/$file/AUSCAN_Issue_Paper_1.pdf)

This paper aims to explore the links between health and peace-building, how health planning can be enhanced by making reference to a peace-building framework, and how a model for

analysis may be developed which can inform the planning, implementation and monitoring of health programs in conflict-affected societies.

The author argues that the scope for health provision in post-conflict contexts is far-reaching and includes building trust and supporting reconciliation, promoting social cohesion, addressing psychosocial responses to conflict and creating healthier environments. It can be used as an entry point to peace building activities in a number of ways:

- Health professionals can act as champions of peace;
- Health systems can, either implicitly or explicitly, become agencies for promoting non-violence, by promoting respect, dignity and non-discrimination in everyday practices;
- Well designed health services can potentially provide a politically 'neutral' space that allows all sectors of society to work towards a common good;
- Health interventions may offer a model for collaborations with various sectors of society, including: state ministries, public, private, and traditional services, non-governmental organisations, civil society and the international community; and
- Health initiatives that draw together families and communities add to the sense of social coherence and cohesion.

The author adds a note of caution however: "There may be extreme contexts in which it is impossible for health to do more than save lives and reduce morbidity, simply because the humanitarian space has been constrained by warring parties and other interests to the point that the pursuit of peace, or the implementation of a peace-building framework in health, is not feasible." (p. 8)

**Jones, S. G. et al., 2006, 'Securing Health: Lessons from Nation-Building Missions', RAND Corporation, US**  
[http://www.rand.org/pubs/monographs/2006/RAND\\_MG321.pdf](http://www.rand.org/pubs/monographs/2006/RAND_MG321.pdf)

This report examines the rebuilding of public health and health care delivery systems in nation-building efforts in post-conflict situations. The study examines a number of case studies, compares the quantitative and qualitative results, and outlines best practices. The case studies include seven cases of nation-building operations following major conflicts: Germany and Japan immediately after World War II; Somalia, Haiti, and Kosovo in the 1990s; and Afghanistan and Iraq since 2001. The study argues that health can have an independent impact on broader political, economic, and security objectives during nation-building operations.

The report outlines various lessons learned from previous post-conflict situations:

- Health care is a major contributor to overall post-conflict nation-building;
- Improved health delivery is deeply impacted by other key sectors including security, basic infrastructure, education, governance, and economic stabilisation;
- Coordination of health efforts is a key challenge during reconstruction;
- Health sector reform must encourage long-term sustainability through local government assuming substantial responsibility for managing the health sector; and
- Short-term medical care is valuable, but reforming a state's health care system requires time and sustained effort by the international community

Additional key points include:

- **Winning hearts and minds:** "Nation-building efforts cannot be successful if adequate attention is not paid to health. Indeed, health can have an important independent impact on nation-building and overall development. Several of the cases

show that health can have a significant impact on security by helping to “win hearts and minds.” This is an important objective in nation-building operations; cases such as Iraq and Somalia demonstrate that the inability to win hearts and minds contributes to insurgency, warlordism, and an unstable security environment. Counterinsurgency experts have long argued that winning hearts and minds is a key—if not *the* key—component in establishing peace. And health can play a key role by, for instance, offering tangible health programs to the local population and meeting basic health needs, such as improving sanitation and nutrition conditions. These programs should be designed to gain support for the host country, rather than for the United States or other outside actors—the local government should be the entity winning the hearts and minds of the population.” (p. 281)

- **Sustainability and tipping points:** “Health sector reform must encourage long-term sustainability. Indeed, a key objective of health reconstruction should be to reach a tipping point—that is, the point at which the local government begins to assume substantial responsibility for managing the health sector and outcomes continue to improve. This point will be different in every nation-building case and will likely take longer to reach in less developed states. It took Germany approximately two and a half years to reach the tipping point [...] Haiti never reached the tipping point. The United States largely withdrew after three years, and the Haitian government never developed the capacity to implement health programs and to administratively operate them. There was no functioning Ministry of Health or administrative personnel within the ministry who could receive donor support, oversee financial administration, and ensure effective implementation. Haiti lacked trained health care workers in the public sector. Since many Haitian professionals had left the country, the remaining personnel were often poorly trained and had little experience in administration or government. Aid organizations and donor states often funnelled resources through the NGO community.

[...] The curves of decline and recovery for states with weak national capacity are likely to differ from those for states with strong national capacity, especially when there has been a long-term degradation of health [...] In Afghanistan, the international community geared up for a standard post-conflict reconstruction effort instead of acknowledging that what it largely faced was a development challenge. If development is the goal, an important question arises: Will health recovery plans perpetuate a tradition of national dependence on the external design, delivery, and financing of health care that will jeopardize sustainability? Unfortunately, the main health challenges in countries with weak national capacities are not amenable to quick fixes. The population must become stronger and healthier through improved nutrition and access to clean water and sanitation; a new generation of health care professionals has to be recruited, trained, and motivated to work in rural areas; and long-standing habits and attitudes (particularly related to marriage, family, and the status of women) must change. Moreover, the country needs years of stability and security for these changes to occur and take hold.” (pp. 290-291)

- **Exit Strategies:** “Short-term medical care is, of course, valuable; but to change a state’s health care system requires time and sustained effort. In several cases we examined, such as Haiti and Somalia, outside powers wanted to withdraw as fast as possible. Our analysis suggests that the search for a fixed exit strategy is illusory, if this means a certain date in the near future when full control of health care facilities can be handed back to local authorities. Exit requires a functioning health care system that has at least reached the tipping point. This point will be different in every nation-building case, and will likely take longer to reach in less developed states. Duration is a critical variable and cuts across all aspects of reconstruction. Based on the cases we examined, no effort to rebuild health after major combat has been successful in less than five years. One important point to make here is that while

staying for a long time does not always guarantee success, leaving early assures failure. U.S.-led efforts to rebuild Somalia and Haiti were short-lived. The bulk of health assistance lasted for only three years, and continuing political instability in Haiti led the international community to withhold all aid by 2000. Haiti and Somalia were also affected by political constraints in the United States. The Clinton administration defined its objectives rather narrowly and was influenced by domestic politics in making its decision to establish short exit strategies and departure deadlines. The cost of early departures is clear: it is difficult to ensure success in rebuilding health.” (p. 294)

**World Health Organisation, 2002, ‘Report on the Second World Health Organization Consultation on Health as a Bridge for Peace’, Ecogia, Versoix, July 8-9**

[http://www.who.int/hac/techguidance/hbp/Versoix\\_consultation\\_report.pdf](http://www.who.int/hac/techguidance/hbp/Versoix_consultation_report.pdf)

This is the report of a consultation the WHO’s Health as a Bridge for Peace (HBP) which aimed to analyse and review the achievements and constraints of the acquired experience on HBP. The basis of the concept of HBP is “that any public health strategy must be built on the principle of equitable unhindered access and must have a wide, long-term perspective of strategic planning, involvement of local actors and international partnerships. When we speak of HBP, we express the need to integrate public health - from analysis, policy and planning to the delivery of care - within cross-sectoral work for social capital. Definitely, in the current international context, this includes conflict management, social reconstruction, and sustainable community reconciliation.” (p. 3)

The paper includes a list of ten mechanisms that constitute the health track to peace as outlined by McMaster University, on the basis of their field experience with health programmes in various post-conflict environments:

1. *“Use of health-related superordinate goals:* A superordinate goal is one that transcends the separate goals of parties to a conflict and that can best be achieved when the parties join efforts (e.g. the humanitarian ceasefire: the children of each party may be dying of diseases that can easily be prevented if warring factions stop fighting and jointly mount an immunization programme). In this case, the health of children has become a superordinate goal.
2. *Evocation and extension of altruism:* Health care is an institutionalized expression of human altruism. When health care can be extended to out-groups treating enemy wounded with the same compassion and professionalism as one’s own wounded or through a variety of other means, a major inroad is made against the objectification and demonization that accompany war and that are essential to its long-term pursuance.
3. *Discovery and dissemination of facts:* Propaganda is essential to the long-term waging of war in the modern period. It can effectively be countered only through the discovery and dissemination of accurate information.
4. *Redefinition of the situation:* The meaning of war is not obvious. Its meaning for a population is established by particular groups--social classes, military elites, media and so on. War can be presented as a game, a test of manhood, a competition of civilizations, a cosmic contest of good and evil. Health workers can refuse to accept these understandings and definitions and can promote different ones. They can promote the understanding of war as a disaster or as a complex emergency
5. *Healing of trauma:* In general, the injuries caused by war slow down a society’s recovery from war. Trauma that is specifically psychological may contribute to demoralization and lack of initiative, as well as to rigid patterns of thinking that perpetuate war and make it chronic. Health care professionals can utilize methods of trauma-healing that are linked to social processes of reconciliation and peace building.

6. *Contribution to civic identity:* In cases where societies have been divided by identity conflicts, people who have an adequate and equitable health care system are strengthened in their sense of belonging to the society or the state that has provided it for them.
7. *Contribution to human security:* An adequate and equitable health care system, which addresses people's basic needs, gives them an essential form of security. If they do not have this form of security they may resort to violence or war to achieve it.
8. *Diplomacy, mediation and conflict transformation:* Health workers are not unique in developing skills in diplomacy, mediation and conflict resolution but they will sometimes have unique opportunities to use these.
9. *Solidarity and support:* Many 'Peace through Health' mechanisms involve solidarity and support for victims of war.
10. *Dissent and non-cooperation:* When health workers are called on to collaborate in 'unjust' wars or preparations for such wars, or in the development of inhumane weapons or war policies, they can refuse to do so." (pp. 7-8)

**Zivetz, L., 2006, 'Health Service Delivery in Early Recovery Fragile States: Lessons from Afghanistan, Cambodia, Mozambique and Timor Leste', USA: Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID), Arlington, VA**

[http://www.basics.org/documents/Early\\_Recovery\\_Fragile\\_States\\_Zivetz\\_Final.pdf](http://www.basics.org/documents/Early_Recovery_Fragile_States_Zivetz_Final.pdf)

This case study explores some key themes in the literature on service delivery in fragile states, based on the health sector experience in four early recovery countries - Afghanistan, Cambodia, Mozambique, and Timor Leste. The analysis considers the various impacts of foreign assistance on state stewardship of the health sector and the programming implications. The investigation starts with state effectiveness and legitimacy. The author finds that United Nations (UN) coordination in all four countries was constrained by state avoidance strategies; a spike in aid flows that were out of sync with emerging government capacity; and—in Cambodia and Mozambique—an emphasis on highly visible but largely unsustainable infrastructure projects that were limited by the absence of a planning framework. The author also argues that donor efforts would be more useful if directed at policy, capacity, and systems strengthening than on enhancing state legitimacy.

The author also explores the idea of politics and health services as a 'peace bridge': "In Mozambique, efforts to reintegrate RENAMO health workers into the health workforce promoted reconciliation (Pavignani and Colombo 2001). Days of Tranquility for immunization campaigns, first used in El Salvador in 1985, have been advanced as an example of a peace bridge (WHO 2002).

But the impact of health services on making or keeping the peace or making a new government legitimate remains largely anecdotal (WHO 2002). Indeed, the opposite may be more to the point. Without a political solution that guarantees stability, a health system cannot get much traction (Pavignani and Colombo 2001). External assistance to rebuild the health sector began in Cambodia, Mozambique, and Timor Leste at the end of the conflict. It is instructive to note how much momentum was possible in rebuilding the health sector in Mozambique and Timor Leste, given the internal political cohesiveness in the post-independence era. In Timor Leste, in less than two years a Department of Health was established under the second transitional government (September 2001). Importantly, Department of Health leaders maintained an ongoing exchange with political leadership throughout the early period. Although there were differences of opinion, the consistent interaction is credited with part of the rebuilding effort's success, even when compared with other sectors. Similar politically empowered cooperation was seen in Mozambique in the early days, as mentioned above (Pavignani and Colombo 2001).

On the other hand, aid in general and health services in particular may be a “blunt instrument” in achieving a political or diplomatic solution. In a prescient pre-9/11 piece on aid as a peacebuilding mechanism, Goodhand and Atkinson (2001) stress the limitations of humanitarian and development assistance in addressing a conflict’s political roots. They cite Afghanistan as a place where aid was the international community’s “smokescreen for inaction.” During the Taliban period, the international community developed a strategic framework for the health sector, but political debates about whether to engage or cease activities with the Taliban regime forestalled realization of the plan (Sondorp 2004).

Conflict, including a foreign military presence, remains a feature of rebuilding efforts in Afghanistan. The re-establishment of health services in Afghanistan is broadly viewed as supportive of wider efforts to stabilize an inherently unstable situation, bolstering the new government’s legitimacy. Following this reasoning, if health is a peace bridge, premature declines or even severance of aid to the health sector would contribute to a disruption of the fragile stasis. Afghanistan—where 90 percent of aid comes from foreign assistance—may be quite vulnerable in this regard.” (pp. 29-30)

**Grove, N. J. and Zwi, A., 2008, ‘Beyond the Log Frame: A New Tool for Examining Health and Peacebuilding Initiatives’, *Development in Practice*, Volume 18, Number 1, pp. 66-81**

This article is available for purchase from Informaworld:

<http://www.informaworld.com/smpp/content~content=a789773310-db=all>

This article explores the theoretical links between health and conflict, as well as the potential for aid to the health sector to contribute to peace. The authors suggest that undertaking health and peace work requires attention to a range of issues that are currently at the periphery of aid delivery. These include trust and social cohesion; sensitivities of culture, conflict, and gender; staff dynamics and agency-government relationships; project governance; and accountability to communities. They argue that making these issues visible and providing a structure for reflecting upon them is necessary if these principles are to influence health work in conflict. The discussion draws on conceptual and practical research conducted over a two-year period, as well as fieldwork undertaken in Sri Lanka, Timor Leste, and the Solomon Islands.

The article has three main sections. In the first the authors discuss the arguments for linking health and peace, and consider some of the difficulties associated with pursuing these activities. The second section presents and critiques the tool most commonly used in the management of aid programmes, the logical framework, and examines its strengths and limitations. The authors then introduce the Health and Peace Building Filter (hereafter referred to as the Peacebuilding Filter), which has been designed to assist donors and others to reflect on health projects and programmes in conflict or fragile settings. They argue that such a tool can help to move the aid community beyond inputs and outputs to examining processes, relationships, and the indirect consequences of aid programmes. An example from one principle in the Peacebuilding Filter – ‘trust’ – is presented to demonstrate how new tools can promote deeper dialogue about health projects and help to put ethical principles into practice.

**Waldman, R., 2006, ‘Health in Fragile States. Country Case Study: Democratic Republic of the Congo’, *Basic Support for Institutionalizing Child Survival (BASICS) for the United States Agency for International Development (USAID)*, Arlington, Virginia, USA**  
[http://www.basics.org/documents/Health\\_in\\_Fragile\\_States\\_DR\\_Congo\\_Waldman\\_Final.pdf](http://www.basics.org/documents/Health_in_Fragile_States_DR_Congo_Waldman_Final.pdf)

This paper argues that a number of lessons have been learned in the early days of health system reconstruction in DRC. One of these is: “Traditional developing country health

programs should not be transplanted *in toto* to recovering geographical areas. Instead, transitional programs that address both health service delivery and drivers of fragility would be best. These would aim to increase the government's legitimacy as well as to improve the population's health status." (p. iv) In fact, "The rebuilding of destroyed facilities and reliable supply of those facilities with motivated personnel and appropriate medicines can contribute to an improved perception of government and, by extension, a lowered risk of the resumption of conflict." (p. v)

Chapter 4 looks at the measures undertaken by the DRC Ministry of Health to address the challenges of an unstable government with little legitimacy in the eyes of the population and continued violence. One of these measures is the Basic Package of Health Services (BPHS), which aims to centrally manage the activities of a range of peripheral health facilities, and to provide guidance to the donors as to what kinds of health programs they should support: "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 of the important armed political factions at the time. This is important in that it suggests that at least a small role for the health sector is possible in forging and possibly in maintaining the fragile peace.

In general, though, "health in fragile states" is a donor concept, not a local one. It is fair to say that the MOH has not, at least not consciously, considered analyzing or specifically addressing the causes of fragility within its borders. Its role within an even weak government structure is to deliver health services to the population. The degree to which it is able to do so may have an impact on the overall level of legitimacy which the population accords to the government, but there is little evidence in general and none in DRC to suggest that even major improvements in health services delivery will be singularly important to the consolidation of the peace process or to a successful passage from transitional government to a more stable political environment." (p. 20)

**Thompson, D., 2008, 'The Role of Medical Diplomacy in Stabilising Afghanistan', Defense Horizons, Number 63**

[http://www.ndu.edu/ctnsp/defense\\_horizons/DH63.pdf](http://www.ndu.edu/ctnsp/defense_horizons/DH63.pdf)

This paper examines the health sector as a microcosm of the larger problems facing the United States and its allies in efforts to stabilise Afghanistan. The author argues that these problems include fragmentation of responsibilities, narrow lines of authorities, and archaic funding mechanisms.

The author argues: "Nowhere is this disorganization more apparent, nor have more opportunities been lost, than in the areas of health and medical care in Afghanistan. Too much effort is wasted on poorly coordinated Medical Civic Action Programs (MEDCAPs), where U.S. and NATO International Security Assistance Force (ISAF) military medical personnel deliver health care directly to Afghan civilians, undercutting the confidence of the local population in their own government's ability to provide essential services. While reasonable people may disagree about the effectiveness of MEDCAPs in nations where there is no functioning government to provide this health care, MEDCAPs in Afghanistan are largely inappropriate because they fail to contribute to long-term capacity-building. These teams are more appropriately used as tactical implementers of reconstruction projects in conjunction with PRTs, as described below." (p. 3)

Instead, the initial focus in Afghanistan should be on health sector reconstruction that directly supports counterinsurgency efforts and lays the foundation for longer-term recovery. This includes medical infrastructure and training institutes that offer entry-level education (literacy, basic scientific and vocational skills) and economic opportunities at the provincial and district levels. These training and economic opportunities should specifically empower women, both

to reverse the regressive effects of the Taliban's exclusion of women from society, and to return health sector staffing to its pre-Taliban gender balance, where women were active participants. "More economic opportunity for women builds individual and community resilience by permitting rural families to survive without needing to please the Taliban insurgents. Specific local requirements should be generated by tactical-level PRTs, perhaps using MEDCAP-like activities; implementation of all local activities should be managed by these PRTs, with adjustments and modifications according to local conditions. As a governance and anticorruption tool, projects should begin in provinces and districts where local government authorities demonstrate their commitment by providing security and reducing poppy cultivation. Unskilled workers who are currently engaged in poppy cultivation can be offered jobs in building construction, a culturally acceptable alternative livelihood. This type of reconstruction will begin to address the pervasive poverty that debilitates the government and facilitates the recruitment of unemployed youths into militias, drug-related activities, and the insurgency. Projects along the Pakistan border will facilitate essential political reform and economic development at the local level." (p. 7)

The author also makes recommendations for health initiatives in the security sector: "Follow-on health sector efforts should focus on rapidly strengthening the institutions required for long-term stability, including health care for uniformed ANP in rural areas and on the borders, development of combat casualty care and evacuation for ANA and ANP in an integrated emergency medical and trauma management system in the civilian sector, and health care for army and police family members in an upgraded civilian health sector. This will improve recruitment and retention of quality personnel into the ANA and ANP and develop professional security institutions. All aspects of health education and training, and the supporting institutions of logistics, communication, and transportation, must be developed to enable the maturation of the ANSF, benefit civilian sector growth, and provide additional economic opportunities. Multisector components include better integration of counternarcotics efforts, taking on preventive education by social marketing, rehabilitation of users, and more comprehensive consideration of alternatives to poppy cultivation. Development of the private sector is possible in health-related areas, such as biomedical equipment repair and maintenance and fee-for-service health care. These and other opportunities will grow when a small degree of stability and security allows private sector investment to take root. Action now to provide a foundation of essential health care services will be the catalyst for these and other reconstruction efforts." (p. 7)

**International Save the Children Alliance, 2006, 'Rewrite the Future: Education for Children in Conflict-Affected Countries', International Save the Children Alliance**

<http://www.savethechildren.org/publications/reports/RewritetheFuture-PolicyReport-1.pdf>

This report argues that education should be made part of all humanitarian responses, including those in conflict situations. The report draws on research that indicates that, across the crisis-to-stability continuum, well-designed education programmes can:

- protect children cognitively, psychologically, socially and physically
- be an essential part of the recovery process for children who have lived through armed conflict
- promote conflict resolution, tolerance, human rights and citizenship
- reduce both poverty and inequality
- lay the foundation for sound governance and effective institutions.

The report offers a series of recommendations throughout the report:

- genuinely listening to children and their needs must be a core part of creating policies, strategies, plans and programmes that will reach children affected by conflict
- it is critical that national authorities, however weak, are brought on board to support and assist in the eventual scaling up of local education innovations
- primary school fees must be abolished
- school curricula should be designed that impart an early understanding of human rights, social justice, teamwork and the process of peace and reconciliation, and which assist children in protecting themselves from dangers associated with conflict
- donors and international agencies must provide quality education as a front line service in all humanitarian responses within the first 30 days
- donors and international agencies should ensure that education as a humanitarian response is resourced and coordinated, and that a percentage of funds raised through UN flash appeals for emergencies are earmarked for the education sector
- promote the creation of alternative basic education programmes that include school outreach centres, out-of-school programmes and flexible-hour schooling
- there is a need to increase allocation of long-term predictable aid for education in conflict-affected fragile states.

**Haider, H., 2009, 'GSDRC Helpdesk Report: Post-conflict Rehabilitation of Education Services', Governance and Social Development Resource Centre, University of Birmingham**

<http://www.gsdrc.org/docs/open/HD567.pdf>

This GSDRC query provides a brief overview and annotated bibliography of resources on education rehabilitation in post-conflict contexts. Drawing on lessons learned from various post-conflict contexts, it finds that the rehabilitation of the education sector requires not re-establishing the system that existed prior to the conflict but rather reforming the whole system. Education rehabilitation goes beyond rebuilding infrastructure and restoring basic education to rebuilding the social fabric of society and developing inclusive education systems. As such conflict-sensitivity must be incorporated into rehabilitation efforts.

### 3. Transitioning to Institution Building

**Brinkerhoff, D., 2008, 'From Humanitarian and Post-Conflict Assistance to Health System Strengthening in Fragile States: Clarifying the Transition and the Role of NGOs', USAID, Arlington, VA**

<http://www.healthsystems2020.org/content/resource/detail/2153/>

This policy brief focuses on the transition from emergency assistance and relief to strengthening the health system for the long term, and the role of nongovernmental organizations (NGOs) and how they can help fragile states to rehabilitate their health systems. The author highlights that in the health sector, post-conflict assistance focuses on three targets of intervention that are broadly sequential:

- Meeting the immediate health needs of conflict-affected populations
- Restoring essential health services
- Rehabilitating the health system.

“The public health system, as a component of the state, needs to develop legitimacy in the eyes of citizens and be seen as effective, responsive, accountable. Th(e) third transition phase puts a premium on capacity building of the health system to enable public health actors to prepare budgets and plans, administer grants and contracts, manage human resources and facilities, handle medicine and equipment logistics, and so on. For example, in postwar Ethiopia, donor willingness to channel rehabilitation resources for essential drugs

through the health ministry helped the new government establish its legitimacy, as well as facilitating a quick return to basic services provision through local health facilities.” (p. 3)

The key to developing effective transition strategies is to build activities that can serve to create a foundation for longer-term health system strengthening into relief efforts to provide immediate access to health services. Transitional programming, then, needs to take into account:

- The need for the public health system (and the state more broadly) to build legitimacy among its citizens by being seen to deliver goods and services; and
- The need to rebuild (or create) sustainable public health system capacity, including in financing, operations, and governance.

To do this, donors should aim to constructively align their relief assistance with country public health agencies to:

- Identify and capitalise on existing sources of capacity (even if very small; also, these may be at the community level, not the centre) and political will as starting points for health system rehabilitation;
- Consider how relief activities can be structured not as stand-alone efforts, but as integral components of an eventual hand-off to country actors (as the case in Box 2 shows); and
- Structure service-provider contracts to create incentives for transitioning service-delivery operations from international NGOs and firms to using NGOs and firms to build local capacity and engage with public health system actors.

**Wheeler, V., Graces, S. and Wesley, M., 2006, 'From Crisis-Response to State-Building: Services and Stability in Conflict-Affected Contexts', Overseas Development Institute, London**

<http://www.odi.org.uk/resources/hpg-publications/commissioned-reports/2006/crisis-response-statebuilding-services-stability-conflict.pdf>

This report is based on experiences from Mozambique, Uganda, Cambodia and East Timor and aims to examine service delivery in countries emerging from conflict from two perspectives:

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

The paper briefly addresses the issue of Quick Impact Projects (QIPs), which are early engagement service delivery projects often, but not solely, provided by the military in post-conflict contexts. The authors argue:

“QIPs have proved controversial. Supporters highlight their perceived, but largely unmeasured, force-protection benefits; detractors stress the absence of a requirement for impartiality, their capacity to blur the distinction between military and humanitarian action, and the military’s relative lack of competence in managing community-based projects.” (p. 6)

While the authors agree that improving the governance and capacity of the state’s service delivery functions is an important element in any state-building initiative, state capacity can be highly variable in post-conflict contexts, and relying solely on state systems to provide social services is often not enough. As a result: “New instruments for closing the service gap

and providing predictable aid are being developed and tested. These reflect donors' desire for greater flexibility and the better integration of interventions, not only between relief and development, but also between security and development. There is also a greater concern among donors to develop ways to effectively intervene in areas of contested legitimacy, and in the highly political process of reform and state-building." (p. 8) Section 2.3 focusses on three different mechanisms for delivering assistance in transitional contexts: social protection programmes, community-driven development and contracting non-state actors. "Each of these approaches seeks to fill the service gap between relief assistance and state-led delivery. They also provide opportunities to address communities' wider security needs, and manage their expectations." (p. 8)

Section 3 looks at how services are being provided by the international community, and not by the state, how can this be done in such a way as to contribute to state legitimacy? How can social protection and improved access to services be managed so that the 'social contract' is reinforced, not weakened? The authors look at the following key issues:

- *Strengthening the social contract:* While state legitimacy can be both legally constituted (through elections or constitutions) and performance-based (through the reliable provision of services and security), performance legitimacy is arguably the more significant influence on citizens' views. State-building initiatives are often characterised by a heavy focus on technical assistance and capacity-building within the public administration. It is important that this to be complemented by assistance aimed at filling the 'service gap' resulting (in part) from state fragility.
- *Programming choices:* If the right aid instruments and approaches are used, effective programmes can be established which can then be progressively handed over to the state, thereby contributing to performance legitimacy. However, identifying when and how actors' roles should change is complex, and should be based in a good understanding of the context, and the state's will and capacity.
- *Harmonisation and alignment:* Harmonisation between donors can reduce demands on under-resourced administrations. Alignment is closely linked to ideas around increasing ownership of those policies and systems by a government, and can have a positive effect on the nascent 'social contract' between the government and its people
- *Joint national programmes:* joint programmes are valuable in post-conflict situations where there might be an advantage for a new institutional regime to demonstrate to the population the "peace dividend" through a limited number of policies that are effectively implemented on an even-handed basis.

#### 4. Further Resources

**Cook, J., 2003, 'Post-conflict Reconstruction of the Health System of Afghanistan: Assisting in the Rehabilitation of a Provincial Hospital - Context and Experience', *Medicine, Conflict and Survival*, Volume 9, Issue 2, pp. 128-141**

This article is available for purchase from Informaworld:

<http://www.informaworld.com/smpp/content~content=a783313107~db=all>

Note: The summary below is taken from the publisher's abstract.

Over more than two decades of conflict, Afghanistan's health system came to depend heavily on assistance from donors and non-governmental organizations (NGOs). When the Taliban fell in November 2001 the health system was in a state of collapse; Afghanistan's health indicators were amongst the worst in the world. National Health Policy is to deliver an essential package of health services to the entire population. It is acknowledged that reconstruction of the health system will depend on donor financial support and NGO involvement in health programmes. An example is Medecins du Monde's involvement in health system rehabilitation in the Ghor province. Investing in health can contribute to peace,

stability and political transition. Security, needed for reconstruction and for NGOs to continue their crucial work in health, has recently deteriorated in parts of Afghanistan. Joint Regional Teams to provide security to outlying areas have been announced by the US. There is concern that their proposed humanitarian and development role could compromise perception of the neutrality and impartiality of NGOs.

**Kirk, J., 2007, 'Education and Fragile States', Globalisation, Societies and Education, Volume 5, Issue 2, pp. 181-200**

This article is available for purchase from Informaworld:

<http://www.informaworld.com/smpp/content~content=a780589275~db=all>

Note: The summary below is taken from the publisher's website.

Within the fragile states agendas and policies of development agencies and organisations education is of concern; education is a social service sector in which the impacts of state fragility are significant, in terms of access and quality of provision for children, working conditions and support for teachers, good governance and legitimacy for the society/community as a whole. However, this article argues that education should be at the centre of fragile states discussions as more than a basic service; in relation to fragility, education is at the same time cause, effect, problem and possible solution. Education needs to be part of fragility analysis as well as in the identification of priority stabilising interventions. In education - as in other sectors and domains - gender equality and state fragility are inherently connected and gender equality must be integrated through all analysis and interventions. The article ends with some recommendations for moving in this direction.

**Etzioni, A., 2007, 'Reconstruction: An Agenda', Journal of Intervention and Statebuilding, Volume 1, Issue 1, pp. 27-45**

This article is available for purchase from Informaworld:

<http://www.informaworld.com/smpp/content~content=a770798444~db=all>

Note: The summary below is taken from the publisher's abstract.

This essay discusses several issues involving the theory of post-conflict reconstruction, and suggests that the concepts of reconstruction and of economic development be carefully kept apart. It explores the question of what moral and legal obligations to reconstruction the occupiers incur. Using Iraq as a case study it presents two scenarios for reconstruction: a 'triage' approach which relies heavily on prioritization and recognition of inherent limitations, and a 'scattergun' approach, exemplified by current efforts in Iraq. The latter, the essay concludes, is ineffective as a tool for reconstruction. Reconstruction has its own intrinsic merits, but using it to win the 'hearts and minds' of a population in order to gain support for the occupiers is unlikely to succeed.

<b>5. Additional information</b>
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**Websites visited**

Google, Google Scholar, WHO, Clingendael, USIP, GSDRC, UNDP Bureau for Crisis Prevention and Recovery, World Bank, UNU-WIDER, ODI, UNICEF

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