

UNITED STATES INSTITUTE OF PEACE WORKING PAPER

Post-Conflict Health Reconstruction:

New Foundations for U.S. Policy

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About This Report

Stabilization and reconstruction activities in the aftermath of protracted armed conflict have been increasingly recognized as critical to aid a suffering population, provide a foundation for a well-governed state, and help prevent renewed conflict. Despite the increasing prominence of global health in U.S. foreign policy, however, the place and priority of health reconstruction as part of post-conflict U.S. stabilization initiatives remains uncertain. This Working Paper explores key questions that need to be answered both to fashion an appropriate policy and structure aid programs to support them. The paper reviews what we know about the impact of war on health and health systems, what we have learned about effective strategies to help states meet the health needs of their populations in the aftermath of conflict, and makes recommendations for an appropriate foundation for post-conflict health recovery, and for the structure of U.S. foreign assistance programs, funding mechanisms, and agency responsibilities, including that of the Department of Defense.

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Executive summary

The stabilization and reconstruction of states emerging from conflict has gained increasing attention in U.S. foreign policy as means to promote well-governed states, avoid future conflict and alleviate the enduring human suffering from war. Over the last two decades, stabilization and reconstruction initiatives supported by the United States and other donors have sometimes included investments in re-establishing – or in some cases, establishing for the first time – a system of health services for the population. Despite the knowledge generated and the encouraging outcomes of many of these programs, however, and the increasing attention to and financial commitments to global health in U.S. foreign assistance, the place and priority of health reconstruction as part of post-conflict U.S. stabilization initiatives remain undefined.

This paper address four key questions about the relationship between health reconstruction and U.S. policy regarding states in and emerging from conflict: First, what do we know about the impact of war on health and health systems? Second, what have we learned about effective strategies to help states meet the health needs of their populations in the aftermath of conflict? Third, what is the appropriate foundation for a policy on post-conflict health recovery? Is it to address dire health consequences of war as a global health priority? To advance peace or prevent renewed conflict in the short term? To win hearts and minds as a means of advancing the image and influence of the U.S. abroad? To help build a legitimate state in the sense of meeting population needs, giving people a stake in the society and advancing human rights? Fourth, if health reconstruction is to be a priority, what are the adjustments needed in U.S. foreign

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assistance programs, funding mechanisms and agency responsibilities, including those of the Department of Defense, given that the department now sees stabilization and reconstruction activities as part of its core mandate?

The impact of war on population, health and health infrastructure, and the emerging strategies for health system reconstruction

The violence and destruction of war brings extends far beyond civilian casualties from 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.

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 policies 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 development and

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implementation of the plan should be based on principles of equity, non-discrimination, quality, community participation, and accountability.

With flexible donor funding mechanisms and early and long-term technical assistance and financial commitments by those donors, adaptation of strategies to local context, and strong local leadership, this approach has the potential to dramatically improve population health and give communities a stake in the health system, even in states that lacked a strong health infrastructure before the conflict began. In many circumstances, national and international NGOs can contribute to the process by implementing programs under the leadership of the ministry of health while also building the capacity of local and district level managers to assume responsibility for key functions. Though hardly without setbacks, this approach has resulted in significantly improved population health in a number of states, even in very difficult environments and sometimes even while the conflict continues. Reliance on leadership through the ministry of health will not always be possible in circumstances of unchecked corruption or weak or uninterested leadership; in those circumstances a foundation for health services must be built either through local and district governments, community-based health organizations, or NGOs, with the aim of nurturing a base of services for future stewardship by government.

Foundations of a policy on health reconstruction by the United States

The prospect of relieving enormous mental and physical suffering stemming from war should be a sufficient reason in itself to prioritize investments in health reconstruction as part of U.S. global health policy, which has begun to view health systems development as a key element. Yet despite the fact that the worst health indicators are typically in countries that have endured armed conflict, especially protracted war, to date neither global health nor post-conflict stabilization policies have included health construction or reconstruction in the wake of armed conflict as a priority. Moreover, despite general recognition of the broad interest of the U.S. in advancing health systems, policymakers are increasingly drawn to narrowly framed instrumental rationales for engagement, such as improving the image and influence of the United States by “winning hearts and minds” of the population, enhancing stability or furthering the legitimacy of the government that provides them.

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One of the most frequently articulated instrumentalist claims is that health investments in post-conflict settings should be supported because they contribute to peace and security in the short or intermediate term. There is little doubt that the health of a population is essential to long-term economic development, which in turn can contribute to peace, and that in some particular circumstances health development seems to have advanced the peace process. Additionally, to the extent that a goal of the stabilization process is to increase the capacity of the state to govern, a competent ministry of health constitutes an element of that capacity. And yet, except in very limited contexts, there exists little empirical evidence one way or the other that, as compared to assuring security, the rule of law, jobs, and good government, developing systems of health services can contribute significantly over the short and intermediate term to reducing the potential for future conflict. There also exists a danger in an approach to investments in health as a means of preventing conflict can produce distortions in policy and spending decisions. It can lead to concentrating on programs and projects that appear most connected to conflict resolution at the expense of comprehensive capacity development that can lead to improvements in population health based on principles of equity, and non-discrimination. The approach can also backfire by stirring resentments among groups or geographical areas that are excluded from the plan.

Another potential foundation for policy is that investments in health can improve the image and influence of the U.S. government in places where it invests, thus “winning hearts and minds.” As with regard to conflict prevention or peacebuilding rationales for engagement in health, there is a paucity of empirical evidence to support this claim one way or the other. This justification, too, can carry costs, particularly in the potential to devote resources to visible projects at the expense of system-building activities that are effective and sustainable. In other words, it cannot be assumed that an approach based on advancing U.S. interests is always consistent with advancing the health of the population. This concern is especially great where U.S. military forces engage in health development activities as part of counterinsurgency or stability operations. Except for support for a host country’s health services for its own military, the Department of Defense’s approach is short term and tactical, project- rather than systems-based, and usually independent of ministry priorities, just the opposite of what a sound reconstruction approach requires. Often, military-generated projects are not linked to

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building a coherent system of services, and not oriented toward building the ministry of health's capacity or a long-term vision that links health facilities with staffing needs. In insecure environments, military engagement in health reconstruction activities can even undermine the safety of health workers.

A more well-grounded rationale for investments in health systems post-conflict, and one congruent with meeting the compelling health needs of a population through systems strengthening, is that they can advance state legitimacy. Legitimacy has two dimensions. The first is that the provision of services may enhance the perception of the population that the government is responsive to people's needs, especially in the long term. Here, too, the empirical evidence is scarce. There are a few cases where it seems that people's positive perceptions about health services led them to have more favorable views of the government (and presumably less likely to resume conflict). But it appears unlikely that the ability to access health services ranks as high as security, jobs, and a functioning justice system in shaping people's behavior. The time required to develop a system of services, moreover, makes it unlikely that health can be a factor in enhancing state legitimacy in the short term.

The second sense of legitimacy is based on values and principles, grounded in ideas of social contract and human rights. It emphasizes local ownership, including communities' role in decisions affecting them, transparency, and accountability. Legitimacy also takes into account human rights notions of promoting equity, ending social exclusion, and prohibiting discrimination. A legitimacy approach also views health as a core social institution that is part of the social contract. According to this view, as an element of legitimacy, a state must assure that key health services (as well as determinants of health such as water and sanitation and social inclusion) are available, that the population has a role in shaping and overseeing them, and that services are based on principles of equity and non-discrimination. This understanding of legitimacy is based on principles rather than on measurement of outcomes, though elements contributing to legitimacy such as transparency and accountability can be measured.

This idea of legitimacy is of special importance in post-conflict environments that are often characterized by high levels of poverty, social exclusion, and interpersonal violence. A health system, if constructed according to the above values, can potentially

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contribute to the amelioration of inequities, power differentials, marginalization, and discrimination that are so often exacerbated by war. It can also be a vehicle for community engagement that can help create stability in the long term. These have not been subjected to assessment, but deserve to be.

Promoting state legitimacy, in tandem with raising the priority of investments in health in places where it is been most compromised, provides a sound basis for policy. Investments in developing a health system under the leadership of the ministry of health recognize that one of the state's central roles is to assure the health of its population, just as it should abide by the rule of law, educate children, and respect human rights. Given the enormous health consequences of war, health should be a high priority in establishing state legitimacy. Moreover, because 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 fueled 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. Accordingly, the U.S. should commit to health reconstruction in post-conflict settings as a global health policy priority as part of initiatives on health systems strengthening and sustain commitments to countries in the rebuilding process so they can bring the process to fruition.

Recommendations for U.S. foreign assistance programs

Based on this analysis, U.S. policy on post-conflict health reconstruction, and the programs to implement it, should be based on six premises:

- Donors, including the United States, should support governments emerging from armed conflict in addressing the extraordinarily deleterious health consequences of war, the destruction of health infrastructure, and loss of health personnel;
- Health is a core social institution, and a health system that operates according to principles of equity of availability access, non-discrimination, participation, transparency, and quality enhances the legitimacy of the emerging government, prospects for future economic development, and long-term stability;

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- When governance circumstances permit, the host government, through its ministry of health, should lead the process of planning and stewardship;
- Community and civil society engagement in planning, monitoring and accountability can both bring about a stronger and more responsive health system and can contribute to the amelioration of inequity, marginalization and discrimination;
- The role of donors and technical experts is, first, to provide intensive financial and technical assistance to build the capacity and skill of the ministry of health to lead the development and implementation of policies and plans for effective health systems, and second, to support the costs of implementation as well as interim services;
- Development of health systems in post-conflict settings is a complex process, requiring donor commitments that begin early, last for many years, and are flexible and tailored to local needs for training, supervision, mentoring, and support.

Applying these premises has four implications for the manner in which aid is structured and implemented within the U.S. government. First, the U.S. should support building system capacity through leadership, skills development, and support for local authority. It should follow widely shared principles of health reconstruction developed through experience in health reconstruction in fragile states. Ministries of health should be provided tools to gain ownership of their programs and set priorities so long as they commit to policies of inclusion, human rights, transparency, and financial responsibility. Support for capacity building should include the functions of planning, policy development, financial management, workforce training and support, service development and oversight, and for accountability mechanisms including the role of communities and civil society. Where the central government cannot or will not exercise these functions because of lack of political will or commitment, such support will have to go to the local or district level, and rely on NGOs and community-based organizations.

Second, the U.S. should create flexible funding mechanisms that support capacity development and ensure concurrent service delivery. Aid mechanisms should be structured so they encourage the development of ministerial capacity for stewardship, planning, and oversight and enable participation by and accountability to communities.

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This approach also means, wherever possible, aligning funding decisions with local priorities and assuring that program branding promotes legitimacy in accordance with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Multilateral approaches can be used to support these objectives. Aid mechanisms can take advantage of tools such as multi-donor trusts and pool funds for ministries, should be open to supporting recurrent costs, and should adjust reporting requirements to capacity-building objectives. Funding commitments must realistically extend over many years, recognizing that economic sustainability will take longer than programmatic sustainability.

A focus on capacity building for health reconstruction should begin as early as possible, often during the emergency phase. Agencies including USAID's Office of Foreign Disaster Assistance and the State Department's Bureau of Population, Refugees and Migration should have authority and budgets to begin the process of support for capacity building even during the emergency phase. Often a ministry of health continues to function, albeit at impaired levels, during the conflict, and opportunities may exist to support the ministry's planning for the future. Similarly, NGOs providing emergency health services can be enlisted to use their services to help build a foundation for the future, including through mechanisms such as the World Health Organization (WHO) led interagency Global Health Cluster.

The lead role for health reconstruction should be placed in United States Agency for International Development (USAID), with the qualification that the agency needs to be greatly strengthened and its staff and expertise expanded. Other global health programs, such as those for malaria and HIV/AIDS, should be well coordinated with health reconstruction activities and resources from these programs integrated into an overall aid approach. This approach differs from the approach of the State Department's Office of the Coordinator of Reconstruction and Stabilization of sending experts to states emerging from conflict for short periods of time to advise governments.

Third, capacity building strategies and aid mechanisms should be structured to assure that community participation and civil society oversight are not afterthoughts, but are central features of the process. Toward that end, resources should be allocated for the purpose of assuring participation and funding accountability mechanisms, including

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monitoring by civil society organizations. Programs to support programs addressing gender-based violence should be integrated into the health system at the community level.

Fourth, the military should have a very limited role in health systems reconstruction, usually restricted to logistical support where needed, since it has neither the mandate nor the skills to engage in the capacity building support activities required for success. Resources for health reconstruction now placed within the Department of Defense should be transferred to civilian agencies and those agencies need to be more robustly staffed.

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1. Introduction

In the past decade, stabilization and reconstruction activities in the aftermath of protracted armed conflict have been increasingly recognized as critical to 1) aid a suffering population, 2) provide a foundation for a well-governed state, and 3) help prevent renewed conflict.ⁱ The Bush administration issued a National Security Presidential Directive to guide policy on the subject and for a time the United States Agency for International Development (USAID) adopted a Fragile States Strategy.ⁱⁱ In countries including East Timor, Afghanistan, Southern Sudan, Liberia, the Democratic Republic of Congo, and Kosovo, health system development has been an element of the reconstruction process, in some instances beginning even as the conflict wore on. These initiatives generated knowledge about effective policies and mechanisms to build effective and accountable health systems in the wake of war.ⁱⁱⁱ Yet the place and priority of health reconstruction as part of post-conflict U.S. stabilization initiatives remain uncertain.

The gap between experience-based knowledge and policy, moreover, exists at a time when U.S. investments in global health have grown dramatically and linkages between health and U.S. foreign policy have increased.^{iv} Entities ranging from the Institute of Medicine to the Council of Foreign Relations have called on the Obama administration to create a new and robust U.S. global health policy and to commit resources sufficient to implement it.^v These entities' recommendations, however, leave the priority of health reconstruction in post-conflict settings largely unaddressed. The Institute of Medicine report, for example, though running nearly 200 pages, devotes only one paragraph to the relationship between war and health and only a sentence to the investments in health systems in the wake of war, asserting the commonly articulated but unproven claim that health investments can avoid or reverse the possibility of future conflict.^{vi}

The policy questions are compelling both because of the suffering of populations from war and the need to develop a comprehensive approach to help societies recover from conflicts. Four key questions need to be answered in order to develop an effective approach:

- First, what do we know about the impact of war on health and health systems?

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- Second, what have we learned about effective strategies to help states meet the health needs of their populations in the aftermath of conflict?
- Third, what are the appropriate foundations for a policy on post-conflict health recovery:
 - To address dire health consequences of war?
 - To advance peace or prevent renewed conflict in the short term?
 - To win hearts and minds as a means of advancing the image of and influence of the U.S. abroad? And/or
 - To help build a legitimate state in the sense of meeting population needs, giving people a stake in the society and advancing human rights?
- Fourth, if health reconstruction is to be a priority, what are the adjustments needed in U.S. foreign assistance programs, funding mechanisms and agency responsibilities, including those of the Department of Defense, given that the Department now sees stabilization and reconstruction activities as part of its core mandate?^{vii}

This paper explores these questions and proposes answers to them.

2. Background: Health, Health Systems and Armed Conflict

2.1 Measuring the impact of armed conflict on health

Civilian casualties have long been a feature of war.^{viii} Death and injuries from direct attacks or as collateral damage from ordnance, including shells, bombs, anti-personnel landmines, and bullets, though horrific, often account for a relatively small percentage of morbidity and mortality from war. In many conflicts, the high rates of civilian morbidity and mortality result from secondary chains of events: these range from disease, malnutrition or other forms of vulnerability stemming from destruction or damage to water supply, power and sanitation systems, physical displacement, suspension of prevention programs and disease surveillance, flight of health workers, destruction of health facilities, the manipulation of humanitarian access, and the stresses of experiencing trauma and war.^{ix} In Kosovo, Liberia, Chechnya, and Mozambique, destruction or severe damage to health facilities reached as high as 80 percent of facilities.^x In Liberia, a post-war survey found that 242 of 293 health clinics were looted or damaged.^{xi} In Iraq, the number of hospital beds declined from a high of 1.95/1000 people in 1970 to a low of 1.3/1000 people in 2003, with an estimated shortage of

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50,000 beds as of 2008.^{xii} The ratio of excess deaths that are not combat or weapons-related tends to be highest in the least developed countries, in part because the health system was weak and undeveloped in the first place, incapable of addressing the extraordinary needs brought on by war.^{xiii}

Historically, there have been no accepted standards for collecting and reporting data on mortality and morbidity, including psychological trauma, from war.^{xiv} Of these, the greatest attention has been paid to civilian deaths. Excess mortality, defined as the death rate due to a conflict that is not directly related to combat, is the most widely used indicator for the impact of conflict on civilian populations.^{xv} One study looked at excess mortality in ten African conflicts and estimated that it ranged from 71 percent to 97 percent of total war-related deaths.^{xvi} In a series of seminal studies, the International Rescue Committee conducted household surveys in the Democratic Republic of Congo to determine the effects of the war on mortality. It undertook five sets of regional and national studies, surveying up to 19,500 households. These studies found that the majority of deaths were non-combat related, and the majority of excess deaths were due to fever, malaria, diarrhea, respiratory infections, and malnutrition. Moreover, improvements in security were associated with a decline or elimination of excess mortality.^{xvii}

Displacement is also associated with excess mortality. The Centre for Research on the Epidemiology of Disasters (CRED) used 90 surveys performed in 13 districts in Angola to determine the effects of the war between 1998 and 2002. By the end of the conflict in 2002, approximately 4.7 million people, or 40 percent of the population, had fled from their homes and were displaced. The displaced people suffered a rate of mortality 82 percent higher than would have been expected based on comparisons to baseline mortality rates in sub-Saharan Africa generally.^{xviii}

Other studies have examined mortality in especially vulnerable groups, including infants, children under the age of five, and women giving birth. In many conflicts, these indicators rise dramatically, and of the 10 countries with the highest mortality rates for the younger than five group, seven are in countries that recently experienced civil conflicts.^{xix} In sub-Saharan Africa, infant mortality averages around 100 per 1000 live births (the world figure is 54), but infant mortality reached 473 in Mozambique, 170 in

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Sierra Leone, and 157 in Liberia.^{xx} The under five years old mortality for Africa averages between 171 per 1000 births (comparable world figure is 79), but in Sierra Leone and Liberia the rates reached 286 and 235 respectively.^{xxi} In refugee populations, most deaths occur among children under the age of five.^{xxii}

Maternal mortality is often a good indicator of the availability of health services, since death during childbirth is most often caused by lack of access to straightforward emergency obstetrical care that any functional health system ought to be able to provide. The already severe shortage of these services in developing countries is often worsened in armed conflict, with the highest maternal mortality ratios in conflict regions. In Liberia, the maternal mortality ratio rose from an already very high 578 per 100,000 births in 1999, just before the last brutal phase of its civil war was about to begin, to 994 per 100,000 in 2005.^{xxiii} And in Sierra Leone, the postwar ratio was 1,800.^{xxiv} In Afghanistan, twenty years of war led to a maternal mortality ratio in 2002 as high as 1,600 per 100,000 live births, and in rural areas far higher; 87 percent of these were preventable. Death during childbirth was estimated to represent half the deaths of women of childbearing age. Moreover, a child who survived childbirth when the mother did not had only a one in four chance of living until its first birthday.^{xxv} Even in middle-income countries, maternal mortality ratios rise significantly in conflict regions. In Chiapas, Mexico, maternal mortality rates were seven times higher than other sections of the country.^{xxvi}

As the Congo studies show, morbidity from infectious disease can increase during war, as does malnutrition, especially among children and displaced people. Survey data from an Angola study found that wasting malnutrition of internally displaced populations was 2.3 times higher than for non-displaced residents during the conflict between 1999 and 2003.^{xxvii} A study comparing 42 sub-Saharan countries reported that countries that had experienced recent conflicts had higher rates of under-five moderately underweight children, another indication of malnutrition.^{xxviii} A study in the Occupied Palestinian Territories found an increase in child growth stunting.^{xxix}

Finally, but not least, psychological trauma escalates dramatically in war. The following table summarizes findings of studies performed to determine post-traumatic stress disorder (PTSD) and depression symptoms among groups of refugees, internally

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displaced persons and residents in conflicts in different regions of the world.^{xxx} While there were no baseline studies to show changes from the prewar period, the levels are generally higher than in a non conflict afflicted population.

Table 1. Populations that meet criteria for mental health problems

Country of conflict	Legal Status	Year of Study	% Pop. with PTSD*	% Pop. with Depression
Northern Uganda	IDP	2005, 2006	54% - 74%	44% - 67%
Guatemala	Refugees	2000	11%	38%
Burma (Kayah)	Refugees	2001	5%	41%
Bosnia	Refugees	1999	18%	23%
Cambodia	Refugees	2003-2005	62%	51%
Afghanistan	Residents	2002, 2003	20%-42%	38%-67%
South Sudan	Residents	2007	36%	49%
* PTSD = Post-traumatic stress disorder				

While PTSD is the most widely assessed condition, other mental disorders and problems such as depression and anxiety, psychosocial dysfunction, somatic symptoms, and functional impairment are found. A survey of war traumatized internally displaced people in Ingushetia and Chechnya in 2004 found that 78-98 percent of the population was at risk of ill health with complaints of somatic symptoms (headaches, joint and muscle pain), anxiety, depression, and social dysfunction.^{xxxi} A similar study conducted among internally displaced people in Northern Uganda in 2006 found lower than normal physical health scores that were associated with the prevalence of fever, malaria, respiratory problems, and diarrhea, with a high percentage of the population meeting symptom criteria for PTSD and depression.^{xxxii} A post-conflict survey comparing populations in Croatia between 1997 and 1999 found that those in war-affected zones exhibited lower activity due to physical difficulties and emotional problems, interference with social functioning, feelings of depression and anxiety, and perceived deterioration of general health when compared to a year earlier.^{xxxiii} A population survey conducted in Lebanon between 2002 and 2003 found that exposure to war increases the odds of the first onset

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of lifetime mental disorders according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, such as mood, anxiety, and impulse-control disorders. And finally, studies conducted in Gaza with children show a prevalence of behavioral problems including lack of motivation, increased fear, anxiety, anger, school absenteeism, and difficulty with sleep and concentration.^{xxxiv}

Aside from adverse impacts from direct exposure to violent conflict, indirect consequences can increase psychosocial stressors that adversely impact mental health. Indirect consequences include the destruction or weakening of a country's economy, infrastructure, civil society, and social networks that would normally provide support, predictability, and security to a population. A recent study conducted among adults exposed to long-term conflict in Kabul, Afghanistan found that daily stressors such as financial hardship, social isolation, and inadequate housing along with exposure to war related events are predictors for culturally defined psychological distress, depression, PTSD, and psychosocial dysfunction.^{xxxv}

The shortages of services and suffering do not end when the fighting stops. For example, years after the peace settlement in Southern Sudan, only 25 percent of the population had access to health services.^{xxxvi} In Liberia, health services in the wake of civil war reached only 41 percent of the population.^{xxxvii} Five years postwar, a survey in Nimba County, Liberia, a location of intense fighting, found that 75 percent of respondents reported that in the past year they experienced a serious health condition, such as fever, malaria, and pain in the limbs, back or neck, for which they did not seek treatment.^{xxxviii}

As war winds down and people make their way home, moreover, key indicators, including infant, child, and maternal mortality, may remain at the startling wartime levels, or even increase as water, power, electricity and sanitation remain severely compromised, clinics remain damaged or unstaffed, prevention programs are stalled, and health workers remain scarce. The return of refugees can add greater demands to an already stressed system and possibly bring new sources of disease to the population. One study, using Disability Adjusted Life Years (DALY) to assess the long term impact of civil wars occurring between 1991 and 1997, found that, as compared to a conflict free country, the loss of healthy years of life for girls under the age of five was 28.5 years per

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100 girls. That figure increased for extreme cases, such as Rwanda, to 53 years lost per 100 children. Further, this reduction in healthy life years was associated with malaria, tuberculosis, respiratory infections, and other infectious diseases. Overall, the researchers asserted that the lingering impact of civil wars was as detrimental as the immediate, acute impact.^{xxxix} Another study using WHO Health Adjusted Life Expectancy (HALE) and data from the Peace Research Institute of Oslo (PRIO) on armed conflict found that each additional conflict a country experiences reduces the number of healthy years of life of its populations by 7 months.^{xl} Similarly, one study of the effect of political violence in sub-Saharan Africa between 1980 and 1997, using public health indicators from the World Bank, found that countries experiencing severe conflict had five percent lower average life expectancy (reduced by 2.35 years), and nine percent higher infant mortality rates.^{xli}

The decline in the health of populations that experience war, moreover, does not convey the disproportionate impacts of war on particularly vulnerable groups, including refugees, displaced persons, and women. Gender-based violence often escalates catastrophically in war and reproductive health services decline, both with potentially devastating impacts on women's health. Additionally, social, religious, and ethnic groups subjected to discrimination and marginalization in the prewar period may suffer greater declines in health during war both because of their being denied equal access to health services, and the denial of determinants of good health, including housing, jobs, and clean water, sanitation, and the power to make decisions over one's own health.^{xlii}

Even in states where ministries of health have managed to function at some minimal level during war – and some do, -- states emerging from conflict are typically without capacities and resources to address the central health needs of their populations. The shortages begin with destruction of infrastructure and loss of human resources, but don't end there. States often lack capacity for needs assessments, mapping, policy development, leadership and governance, service delivery, information systems, financing, workforce planning and training, outreach, and medical supplies and technology.^{xliii} In many places, some or all of these capacities did not exist even before the conflict, resulting in health services that were weak in terms of coverage, inefficient (e.g., too high an emphasis on tertiary care), ineffective or very inequitable.^{xliv} Moreover, corruption and poor governance can impede an effective response.

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In response to the burdens on health in war, the international relief community has developed ever more sophisticated responses to the destruction of health facilities and the acute impact of war on health. Donors are relatively generous in funding emergency services that reduce mortality in health crises caused by war. Standards established through the Sphere Project, a process aimed at improving how aid agencies fulfill basic human rights in health, water, sanitation and nutrition, coordination through the U.N.'s Office for Coordination of Humanitarian Assistance (OCHA), and increased use of public health surveillance and intervention, can and do lower mortality and morbidity in these challenging environments.^{xlv} U.S. policy supports a strictly humanitarian approach to emergency services in conflict, and USAID's Office of Foreign Disaster Assistance and the State Department's Bureau of Population, Refugees and Migration have considerable flexibility in meeting these needs. In many countries, moreover, ministries of health and local clinics struggle to continue to function, albeit at a reduced level, in the midst of war.

Finally, unless there are strong political interests at work, once war winds down, donors' commitments to the health and other needs of war-affected populations decline, a practice evident in Cambodia, Southern Sudan, Somalia, the Democratic Republic of the Congo, and Mozambique.^{xlvi} Emergency relief funds may drop just as the time that mortality rates are highest, during the transition period between conflict and post-conflict, as happened in Angola.^{xlvii} In Northern Uganda, as soon as the Lord's Resistance Army presence began to decline in 2006, donor funding for health activities declined by about 25 percent in the following year.^{xlviii} Political considerations can lead to greater investment, as happened in East Timor, Kosovo, Liberia, and Afghanistan. But these are exceptions. Overall, a study of aid to post-conflict countries in 2006 found that only five states received 75 percent of development assistance allocated to fragile states.^{xlix}

2.2. Health Reconstruction: emerging principles and challenges

One response to severe health crises stemming from war is to extend emergency relief programs into the post-conflict period. But there are good reasons why there is little support for that approach except as a stopgap or transitional measure. The perpetuation of an emergency-oriented model of services is not only unsustainable but can undermine

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the establishment or restoration of a government able to meet its obligations to provide services to its people.

The alternative is construction or reconstruction of a functional health system. Based on experiences in Sudan, East Timor, Democratic Republic of the Congo, Afghanistan, Liberia, Sierra Leone and elsewhere, an international consensus on principles for health reconstruction is emerging to guide decisions on addressing both the acute and ongoing health needs of the population.ⁱ These principles begin with taking a comprehensive systems-based approach to health and, where feasible, building the capacity of the state ministry of health to engage in the essential tasks of leadership, planning, and oversight of the development of a system based on primary care and centered in communities. The ministry should have the capacity, skill sets, and human and financial resources to develop and implement a health strategy that can serve the health needs of the population. The strategy should be based on sound assessments of health needs resources and should involve broad community participation as “co-owners” of service programs, participating in every aspect from assessments to evaluations of services to accountability.ⁱⁱ The resulting plan should address health services, implementation and support strategies, disease surveillance, disease prevention (including vaccinations), health information systems, supply chain management, human resources for health, and monitoring and evaluations, among other elements. It should also be grounded in principles of non-discrimination, equity, affordability, quality and accountability.

In a number of places, including the Congo, Afghanistan, Southern Sudan, and Afghanistan, the focal point of planning has been a basic package of health services designed to have the greatest impact on reducing morbidity and mortality. The primary care focus of a basic package of health services means privileging investments in community-based clinical services over initial major resource commitments to hospitals that are typically in urban areas.

Process requirements, including transparency, participation by communities and monitoring and accountability mechanisms are also considered key.ⁱⁱⁱ Participation is a value in itself, and also can improve the quality of services and willingness of marginalized people to take advantage of them.ⁱⁱⁱⁱ As Stephen Commins has shown, to succeed, capacity building and service delivery must reinforce each other, and this can

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only happen through the difficult path of designing processes of accountability between policy makers and providers, citizens and policy makers, and citizens and providers.^{liv} The path of accountability to the community may well shift from the service provider to the government.

It is well understood, of course, that these capacity building and system development activities must take place alongside initiatives to meet the acute health service needs of the population. Although there is inevitable tension between these two needs, there is broad acceptance of the imperative of doing both. Given the long time-frame and political support required for capacity development, policy formation, implementation planning and human resource development, to the extent possible, local and national capacity should be supported as early as possible during the emergency relief stage, and activities and funding should overlap and be iterative to meet multiple objectives.^{lv} To achieve the dual objectives of service delivery and indigenous capacity development, some current models rely on international or local NGOs to fill the gap in service delivery while integrating local capacity-building into their program. To enhance the authority of the ministry of health over service delivery, in some cases, rather than funding NGOs directly, donors have provided funding to ministries of health to contract with NGO's to provide services specified in its plan.

There is growing consensus, too, around aid mechanisms and policies that can achieve these purposes, following principles of aid effectiveness in fragile states adopted in the Paris Declaration on Aid Effectiveness and follow-up by the Accra Agenda for Action and the Organization for Economic Cooperation and Development Principles for International Engagement in Fragile States and Situations.^{lvi} In post-conflict environments, these principles emphasize state ownership and capacity-building and the alignment of donor funding mechanisms with the recipient state's political, security and development objectives. Mechanisms such as multi-donor trust funds, budget support or pool funds can help achieve these objectives. At the same time, they must be sufficiently flexible to adapt to local circumstances and needs.^{lvii} From a funding standpoint, it is also accepted in the health reconstruction field that the metaphor of a "handoff" from relief to development activities is misleading, since the process needs to be progressive rather than subject to a bright line. Maintaining a sharp distinction between the two tends to postpone or even defeat local ownership and control of the health development process

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as well as restrict effective use of funds during the emergency phase for long term development. Moving away from the concept of “handoff” can lead to more flexible funding mechanisms that both prevent a gap in funding and avoid shortcuts that exclude participation of civil society or delay operational authority by the ministry of health.

Finally, the enormity of the task requires long funding commitments. Health reconstruction takes years and it is unrealistic to believe a state can pick up the costs in less than a decade, or perhaps two. A recent study from the Center for Global Development showed that effective post-conflict development can take fifteen years or more, and commitments should be structured to provide for long-term commitments.^{lviii} In Liberia, a national health plan and strategy is in place and donors have provided resources to develop a system that can provide primary health services, train new health workers, and put other essential elements into place. Donors are now funding about 80 percent of health service and development activities, though even with that infusion of funds Liberia remains below the \$34 per capita minimum recommended by the WHO Commission on Macroeconomics and Health. The Liberian Ministry of Finance notes that even if there is very robust economic development in Liberia, there is no prospect in the next decade for the government to assume more than a fraction of the costs of a health system needed to reduce mortality and morbidity from now-catastrophic levels.^{lix} The idea that intensive support to provide technical assistance, planning, and management training will suffice to rebuild the system is fanciful because it does not take into account the cost of services and the training of personnel to staff them. Long-term donor commitments to health will be essential if Liberia is to realize the vision contained in its plan. USAID has a five year commitment of more than \$50 million for a program to rebuild health services, but officials there recognize that after the five years, it will have to be renewed or the new system will collapse. The same is true elsewhere, and it is simply naïve to speak of sustainability of health systems in the absence of a long-term financial commitment.

Many of these principles and strategies are applicable to health systems development in poor countries generally, but in the aftermath of war the challenges of executing them are amplified by the legacy of destruction, displacement, trauma, migration of health workers, frequent increases in gender-based violence, and political volatility.

Administrators with the commitment and skills to engage in management as well as

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planning and oversight, may be in short supply, and resources are insufficient to implement good policy.^{lx} Corruption or lack of leadership may pose significant obstacles to development. Finally, where security is poor, forces opposing the government may view NGOs implementing ministry-sponsored plans as pro-government and subject to attack.^{lxi} These factors require careful calibration about ways to maximize the chances of success in state responsibility for service delivery, and in some cases may require deviation from state ministry leadership.^{lxii}

Moreover, the NGOs that provide health services during the conflict can contribute enormously to capacity building, training, and support for communities in preparing for the post-war era. But they also often work outside any organized system of governance, and in that sense may inadvertently contribute to a delay in developing and implementing policies, strategies and programs through a ministry of health. Additionally, NGOs with expertise in humanitarian relief may not have the skills and approaches suitable to supporting the development of state-run services. Moreover, during these transitions, ministries of health may find it difficult to exercise authority over NGOs that have independent sources of funding. The World Health Organization's Division of Health in Crises, through its leadership of the health NGO coordinating body called the Global Health Cluster, has a policy of assuring that health-related NGO's contribute to the recovery process, but to date this has been more of an aspiration than a reality.

As a result of these challenges, major shifts in practice or donor policy are only slowly matching a broad agreement on principles. Donor financing mechanisms and policies are often not in harmony with the principles they espouse regarding health reconstruction.^{lxiii} Factors that contributed to war such as ethnic discrimination and other social tensions may well continue to affect the quality of and access to health services, or even the commitment to health reconstruction.^{lxiv} Leadership at ministries of health -- and support for those ministries at higher levels of government -- varies considerably. As a result, the record of health reconstruction in post-conflict settings of efforts to date is mixed.^{lxv} In Southern Sudan, for example, shortages of donor and national resources to pay for salaries, drugs and other necessities, lack of management capacity at national and local levels, and severe shortage of health workers, together with the sheer size of the region, has impeded health systems development.^{lxvi} In northern Uganda, despite an

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elaborate planning process to restore health services in the north, it is not at all clear that the government is prepared to make needed financial or programmatic commitments to build a system of services in the region, given the entrenched and continuing marginalization of the Acholi people.^{lxvii}

Yet, despite the enormous complexity of the task, problems in donor harmonization, tensions between service delivery and capacity building, and conflicts between strengthening states and enhancing participation, there are quite promising initiatives underway. With local leadership and commitment and flexible and sufficient sources of aid, ministries of health are showing potential to strengthen government capacity, meet people's needs, engage communities, and protect human rights.

In Liberia, for example, the minister of health, despite a late start, with the support of the president and after broad consultation, established a visionary national health plan. Donors were generous with technical assistance and have shown willingness to finance ongoing "emergency" services as well as needed assessments, human resource training programs for nurses, midwives and doctors, accreditation programs, community-based prevention, and other key dimensions of a successful system. Total donor commitments to health amount to about \$80 million in calendar year 2009, which will enable hundreds of clinics to administer a basic package of health services through partnerships between NGOs and counties, with commitments to both service and capacity building. Some donors (though not the U.S. government) have been willing to pool their resources in a special fund within the Ministry of Health and Social Welfare that enables the ministry to use the funds in support of its priorities. Immense challenges remain in Liberia. They include the crushing impact of war on physical and mental health, the legacy of gender-based violence, the continuing lack of access to clean water, sanitation, electricity and transport for much of the population, the difficult transition from an NGO-run structure to state-controlled services (even if run by NGOs), and obstacles to developing local capacity. There are also inefficiencies stemming from the structure of aid programs. The initial implementation has been very encouraging, and the outlook for improved health indicators is good.

In Afghanistan, the challenge has been, if anything, greater. Twenty years of war in an already impoverished nation with little health infrastructure outside cities, poor national

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governance, ongoing fighting that prevents 20 percent or more of the population from reaching services, corruption, and an economy based on poppies made the prospect of improving health outcomes unlikely. But even as fighting has continued, USAID, the World Bank, and the EU combined to strengthen the capacity of the ministry of health to oversee administration of a basic package of health services, which are mostly provided through contracts with NGOs.^{lxviii} This investment in health represents just 3 percent of U.S. aid to Afghanistan.^{lxix} But the recent results are impressive: a major expansion of the availability of primary health services and the reach of vaccination programs, and rapid improvements in key health indicators. For example, infant and under-5 mortality declined by 22 percent and 26 percent respectively, between 2002 and 2006.^{lxx}

3. Foundations of a Policy

If knowledge about promising approaches to post-conflict health reconstruction is fast advancing, U.S. policy to support them is not. Indeed, one of the more surprising challenges of promoting a more robust and coherent response to the devastation of health in conflict is confusion about the basis for action. The fundamental questions are whether and in what circumstances the U.S. should make post-conflict health reconstruction a priority. The answers are needed not simply to justify the expenditure of resources, but because the policy on which the interventions and investments are based will have a major impact on the nature of the interventions supported.

Current U.S. policy on post-conflict health reconstruction is confusing and ad hoc, a mixture of claims about enhancing stability, increasing security, engaging with states of strategic importance to the U.S., and advancing health for health's sake. Current aid mechanisms have been correctly described as "piecemeal and incomplete," and indeed the very structures of foreign assistance sometimes inhibit a response that can strengthen a state's ability to run effective health services.^{lxxi}

The lack of policy is, in part, a product of uncertainty about whether health should be a priority in post-conflict environments. There is general agreement that stabilization in the aftermath of war requires, first and foremost, security for the population, which includes demobilization of combatants and the establishment of effective policing, good governance, the rule of law, and creation of jobs. It is not clear where health fits into this

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equation. Global health policy generally emphasizes that American values and capabilities provide the U.S. with a strong interest in alleviating preventable broad-scale suffering, in promoting the ability of people everywhere to lead more healthy lives, in advancing economic development, in demonstrating U.S. global leadership, and in promoting human security.^{lxxii} The Institute of Medicine expresses the general rational interest in supporting global health as follows:

The president should highlight health as a pillar of U.S. foreign policy. The U.S. government should act in the global interest, recognizing that long-term diplomatic, economic, and security benefits for the United States will follow. Priorities should be established on the basis of achieving sustained health gains most effectively, rather than on short-term strategic or tactical U.S. interests.^{lxxiii}

This approach has led to increasing recognition of the importance of initiatives for health systems strengthening, including support for health workforce development, even within disease-specific programs. Within this framework, given the extent of deprivation and hence the greatest need, the compelling potential of saving many lives, and the special challenges resulting from destruction and insecurity, there are compelling reasons to join with multilateral partners to make investments in health systems development in countries emerging from conflict among the highest priorities.^{lxxiv}

Most discussions of global health policy, however, give almost no attention to the priority of investment in post-conflict health reconstruction. Global health discourse especially neglects to address the effect of the ravages of war on both human beings and human systems. If consideration of health in post-war environments takes place at all, it is within the context of stabilization and reconstruction activities. Those conversations, though, tend to consider health services only as an afterthought after security governance, rule of law, and economic development. Health is often lumped into a category of assuring basic services to the population without any consideration of its priority, the financial and other commitments required, and the objectives of the investments. The Bush administration's National Security Presidential Directive 44, which applies to post-conflict reconstruction and stabilization, seeks to achieve peace, security, development, democratic practices, market economies, and the rule of law. Health goes unmentioned. The State Department Office of the Coordinator of Reconstruction and Stabilization,

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created as a result of the directive, has begun to include a handful of health specialists as part of its goal of creating a corps of experts to provide technical assistance in stabilization, but their role and extent of expertise remain unclear. Proposals for a strengthened Office of the Coordinator envision intensive U.S. staffing support of state building, including establishing the rule of law and civil society engagement.^{lxxv} But the model may not work for health, where emergency relief programs themselves must be structured to promote intensive engagement at a far earlier stage, and where providing technical expertise for a short time is insufficient to achieve meaningful results.

In 2004, USAID established a Fragile States Strategy and while its status is uncertain, the agency engaged in a number of important initiatives supporting post-conflict health systems development in the Congo, Southern Sudan, Liberia, and Afghanistan.^{lxxvi} The Fragile States Strategy posited health as an institution fundamental to lasting recovery and transformational development and one that can reduce stress and vulnerability especially among poor populations. But despite the investments made to date, its priority is not clear in stated principles for engagement. It is also vague on the priority of health for resource commitments, as well as on how agency programs need to be adjusted to support the priority. The open-endedness of USAID's Fragile States Strategy, moreover, has sometimes been interpreted to seek to employ health investments instrumentally, for example, to prioritize services in geographical areas that appear most at risk of re-entering conflict, or to serve politically important groups, rather than building a health system that can meet the requirements of comprehensiveness, equity, and non-discrimination.^{lxxvii}

Given this vacuum, a variety of instrumental rationales have been put forward to justify attention to and investments in restoration or creation of a sustainable health system in the aftermath of conflict. These include health as a means to achieve peace and prevent future conflict, to advance U.S. image and power, or to promote state legitimacy.

3.1 Peace, security, and conflict prevention

The most frequently articulated basis for policy is that investing in health will advance the peace process and contribute to the resolution of tensions that affect the security of the population. According to this rationale, including health in stabilization activities can also

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contribute to the protection of the U.S. from threats deriving from instability, including eliminating potential havens for terrorists. In other contexts, such as control of the global spread of infectious disease or prevention of use of biological weapons, the connection between health and national security is reasonably direct, though its strength has been questioned.^{lxxviii} Here the claim is made that health will promote peace by building relationships across ethnic or religious divides and will provide a reason for avoiding future war.

The power of the relationship between health and security depends on the level of generality on which the claim is made. A healthy population is an important element of social capital, particularly for the workforce needed for an economy, and some evidence exists that improved health status correlates with a stronger economy.^{lxxix} A stronger economy correlates with a lower likelihood of renewal of conflict.^{lxxx} Moreover, strengthening the capacity of ministries of health to engage in stewardship, management, and oversight of health systems development is an element of state-building more generally, adding to the number of functions the state can perform and possibly serving as a model to other ministries.^{lxxxi} More direct connections between building state health capacity, service delivery, and preventing violence, however, remain unproven, and there exists almost no empirical evidence to support or refute the proposition that investments in health system strengthening directly promote peace and security in the short or medium term,^{lxxxii} particularly as compared with generally agreed interventions relating to security, jobs, and the rule of law.^{lxxxiii}

Similarly, the claim that establishing health services is a “bridge to peace” by bringing warring factions or communities together toward a common end depends on the level of generality on which they are made. There have been some successful initiatives, but the connection between positive outcomes of such initiatives and preventing future conflict remains unclear.^{lxxxiv} By the same token, the cooperation of health professionals across communities in conflict and cease-fires for vaccination campaigns may contribute to the foundations of a stable society in the long term. The relationship between these initiatives to short- and intermediate-term conflict prevention remains speculative.^{lxxxv}

There are some circumstances where investments in the health sector appear to have significantly contributed to peacemaking. As Enrico Pavignani and Alessandro Colombo

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pointed out in the 1990's, health administration is often characterized as both universally good and politically neutral, but in the real world, especially in regions of conflict, it is highly political.^{lxxxvi} Based on studies in Mozambique and Angola, they concluded that health could possibly play a positive role if a sustained investment in the sector before the war made it politically significant to contenders. In Mozambique, the government had a previous commitment to health services, and the restoration of services in RENAMO-controlled areas signaled a return to normalization. Even there, however, it is not known the degree to which health contributed to peace as compared to other factors. On the other hand, the failure to address underlying sources of tension in reconstituted health services can serve to exacerbate those tensions.

In some situations, the politics or the intractability of the conflict overwhelms cooperative efforts for health. Israeli and Palestinian health professionals have cooperated in many projects over the years, and can provide a foundation for positive relationships in the future, but their impact on the political issues that kept the conflict going is marginal at best. Once a peace agreement comes, there will be foundations for further civil society cooperation. Inferences from cases where tensions within the health sector exist after a peace agreement suggest similarly marginal impacts on the larger political picture. In Kosovo, post-war health services have been ethnically segregated, first by necessity but then by inertia and lack of political will. The legacy of continued segregation contributes to ethnic tension today, which in turn has led to demoralization and widespread belief that the government is not capable of serving the people's needs.^{lxxxvii} Yet it is uncertain how the tensions regarding health services independently contribute to the ongoing political problems in any significant way.

One response to the uncertain connection between health services and short-term peace-building activities is to take a more modest approach and focus on assuring ongoing humanitarian aid to the population or, in highly insecure environments, using military units to support the resupply of hospitals and clinics with essential goods and preventing looting and destruction. These activities can, in some circumstances, contribute to the foundation for future health reconstruction, but should not be confused with development because they are short-term interventions disconnected from a larger set of policies and plans. Another response is to try to tailor health interventions to situations where they seem most likely to have an impact on ameliorating or preventing

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conflict. For example, in the Democratic Republic of the Congo, USAID decided to focus health services development in areas of the greatest insecurity in the hope that they could contribute to greater stability in those regions.^{lxxxviii} In Afghanistan, USAID resources for health services may be redirected to southern and eastern areas where the conflict is most intense in the belief that such investments can lead to greater stability. There is no way to judge whether focusing health activities in insecure areas will make a difference, and there are anecdotal reports that this approach easily backfires when communities that did not receive support become angry; one observer in Afghanistan called this a “peace penalty.”^{lxxxix} More important, taking this approach can actually undermine the principles of health reconstruction discussed above, especially the goal of enabling emerging states to determine and control their own strategies and the approach of abiding by principles of equity and non discrimination. It might even increase tensions in the medium and longer term because it essentially penalizes more stable areas and creates a potential for new sources of resentment. Finally, a stabilization approach is inherently volatile, temporary, and highly inconsistent with building capacity and sustaining a system of services.

As a result, grounding health reconstruction activities on furthering peace and security, if invoked at all, is only justifiable if it is seen as part of a long-term strategy of state-building through economic and service development.

3.2 Winning hearts and minds

Another argument in favor of investments in health post-conflict is that it is a means of winning hearts and minds of the affected population. The idea is used in two different ways that are often confused. One is a diplomatic strategy to advance a favorable view of the United States, especially in countries of strategic interest to the United States, while the other focusing on ability of the indigenous government to gain the trust of its people. This section is concerned especially with the former; the latter is discussed in the next section.

The idea of winning hearts and minds toward a favorable view of the U.S. is usually seen as a means to advance American interests and strategic objectives by showing a willingness to invest in meeting human needs rather than using military means.

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Proponents claim that this approach “strengthens America’s moral leadership in the world by increasing its reputation as a benevolent power, improving our ability to persuade other nations to support our foreign policy objectives.”^{xc} In other contexts, the phrase is used more narrowly, to gain the support of particular communities or populations during or after a war.

Both uses have become central justifications for increasing levels of foreign assistance and for new military doctrines on fighting counter-insurgency that seek to gain the allegiance of U.S.-supported parties.^{xcj} As a general rationale for foreign assistance, the idea that aid improves the image and influence of the United States is sensible, even in the absence of proof of effectiveness. The evidence that aid for health reconstruction in the complex and volatile circumstances of conflict or post-conflict health reconstruction gains, or does not gain, the U.S. favor, however, simply does not exist. In Afghanistan, an early evaluation found no evidence that Afghans associated aid programs with either U.S. or Afghan authorities.^{xcj}

Whatever empirical evidence emerges, however, the use of a hearts and minds approach to aid in these circumstances is deeply problematic. In the first place, the hearts and minds approach is not as benign as it seems. At the very least, the approach complicates the already complex challenges of post-conflict health reconstruction by adding an objective, advancing U.S. objectives, to the already difficult development task. More important, it is based on the assumption that there is no tension between the investments and program interventions that flow from a development approach -- which is based on meeting needs of people -- and those that are a product of efforts to enhance U.S. influence. But this assumption, akin to doing well by doing good, is false, since interventions designed to advance a hearts and minds strategy can be quite different from, and indeed distortions of, programs designed to enhanced system and capacity building. At the simplest level, a hearts and minds approach would likely lead to a preference for quick impact, visible, media friendly projects rather than essential but relatively invisible aspects of capacity building like supply chain, human resource, or financial management curricula for human resources development. Indeed, there is a growing skepticism in the public health field regarding projects with a rapid impact, which may sometimes yield political gains, because their contribution to the sustained recovery of the health service has tended to be modest. Indeed, by absorbing important resources

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and attracting scarce capacity, in the long run their net effect on service delivery can even be negative.^{xciii}

It should be understood, of course, that a systems-based approach needs to generate visible services in the short-term that can give people confidence that their immediate needs are being addressed. But that is quite different from an approach whose very objective is to seek positive attention for the U.S. Harmony between the two objectives can only potentially be achieved in the long-term, based on real achievements in building systems to meet real needs, and it remains speculative whether it will be achieved at all.

Other distortions follow from a hearts and minds approach as well. To the extent projects are labeled and promoted as a product of the generosity of the United States, the approach conflicts with the pressing need is to establish the legitimacy and capability of the host government. A minister of health commented that while donors claim to seek to enhance the legitimacy of government by showing that it can provide services to people, the signage on clinics and vehicles they fund undermines that very legitimacy by touting the role the donor has played in making these services available.^{xciv} Finally, a hearts and minds approach is inconsistent with the multilateral approaches to funding post-conflict health reconstruction that are needed to assure joint donor strategies and reduce burdens on governments emerging from conflict.

The hearts and minds approach that is part of the military's engagement in health reconstruction raises additional concerns, even beyond controversies about the role of Provincial Reconstruction Teams (PRTs) and other military units in the delivery of humanitarian aid and health services. A U.S. military role in post-conflict health reconstruction (as opposed to helping assure continuity of local services or, in some cases, delivery of humanitarian relief) is often justified on the grounds that military-based humanitarian assistance and reconstruction are elements of a strategy to fight terrorism and preventing future conflicts.^{*xcv} And there is no doubt that the military is engaged in health-reconstruction activities, not only in places where it is involved in combat, but in countries emerging from conflict. The U.S. military spends the largest percentage of

*From the U.S. military's point of view, these interventions may also seek to win the population's allegiance for the government the U.S. is supporting, as in Afghanistan. This potential basis for policy is discussed in the next section, but considerations for the military role in health reconstruction are the same.

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national humanitarian and development aid of any OECD country, in 2005 about 20 percent of total aid committed by the United States,^{xcvi} though this percentage is distorted somewhat by spending in Iraq and Afghanistan.^{xcvii} The Department of Defense does not separately track its spending on health, which includes funds spent on health activities by field commanders, much less specifically on health reconstruction. The figure, however, is likely to be large. Apart from assistance to foreign militaries, however, the amount the Department of Defense spends on humanitarian and development health activities has been estimated to be at least \$1.5 billion, which includes research.^{xcviii} The idea of military engagement in health reconstruction in conflict regions is becoming part of military doctrine and may play a prominent role in the new African Command, AFRICOM.

Military involvement poses a high potential for deviation from principles of health reconstruction outlined above. There is some recognition within the military that in post-conflict stability operations the goal should be to enhance the host nation's capacity rather than to provide direct services,^{xcix} but the structural obstacles to following this course run deep. Department of Defense participation in development programs is expected to serve strategic objectives and only secondarily to promote development.^c For example, the Commander's Emergency Response Program (CERP), which provides resources to military officers in the field to support local projects, has been aptly described as a weapon of war. Quick impact projects that can gain favor with a local population are often seen as an element of force protection.^{ci} While in some circumstances military and development objectives may be in harmony at a high level of generality, e.g., promoting stability, at the ground level conflict between the two is almost inevitable.

First, principles of health reconstruction, such as enhancing local capacity and providing equitable, non-discriminatory services may have to be sacrificed to achieve military advantage by meeting the requests or demands of a militarily or politically important ethnic or religious group, clan, or tribe. It is highly unlikely that principles of equity or non-discrimination, much less community participation and accountability, can or will be followed in such circumstances. Second, NGOs report that services run by or in conjunction with the military in Afghanistan can endanger the population or local or international service providers receiving funds. Where an enemy understands that a

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health intervention is designed for strategic purposes, health facilities and workers easily become a target, and the safety of development projects and personnel who are in the vicinity may be placed in jeopardy.^{cii}

Third, military interventions are usually designed to be short-term to gain tactical advantage. For example, Provincial Reconstruction Teams are designed to be “opportunistic and idiosyncratic,” with a purpose of achieving immediate results.^{ciii} Indeed, evaluation of outcomes, even in the relatively short term, is not part of the mission.^{civ} This is, in part, a function of the fact that deployments are short-term, but also linked to narrow military objectives. And these short-term interventions can be inconsistent with and, indeed undermine, long-term development. In Iraq, Medical Civic Assistances Programs (MEDCAPS) alienated the local population because they undermined local medical services, offered little follow-up or continuity of services, and were remote from the needs of the population. A military physician described these as aptly as “drive by operations” that provide “band-aid” medicine:

We provide no enduring medical care. As in Vietnam, a MEDCAP-like operation in Iraq often consists of a temporary “clinic” staffed by a physician or physician’s assistant and supported by several medics. We advertise the clinic for a short time in the local community, rush as many patients through as can be seen in a couple of hours, and then hastily decamp. We distribute over-the-counter medications to patients and then discover the medicine we dispensed being sold on the black market...All too often, the local citizens’ unmet expectations lead to their dissatisfaction and distrust of U.S. forces.^{cv}

Needless to say, attempts can be made to structure interventions to be more responsive to needs and consistent with longer-term goals. In Iraq, for example, some local commanders took an alternative approach of trying to support local Iraqi health facilities and working with local NGOs.^{cvi} Still, given the requirements of military strategy, it would be difficult to link short-term interventions, even if done well, to long-term development objectives. Even advocates of a military role in development assistance have argued that such interventions are only appropriate where a near-term security objective is the primary focus of the intervention.^{cvi}

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Fourth, by their very nature, military programs are highly fragmented internally and also not a product of the priorities of the ministry of health it purports to support. In more secure post-conflict environments, there may be some level of consultation with local ministries, but even then funds are earmarked for particular kinds of projects that flow from U.S. funding structures not priorities of the ministry. The support programs are administratively complex, subject to different authorities and decision-making, and hard to coordinate. The small projects also add to the burdens of state ministries that already have to deal with the proliferation of donor-sponsored projects and have little management capacity to waste. In insecure environments consultation between U.S. military commanders in the field and ministry officials is episodic and inconsistent, if it occurs at all. Even health professional training programs are not typically grounded in or coordinated with civilian or ministry initiatives, and the logistics of coordination are quite difficult to achieve.

Two cases, in very different environments, illustrate these structural issues. In Liberia, USAID, along with other donors, is investing heavily in building the capacity of the Ministry of Health and Social Welfare to build a comprehensive and accountable system of health services, including support for human resource development. For its part, the Department of Defense engages in direct support of the Liberian Armed Forces as a means to help assure that the country remains stable and secure, which includes initiatives to reduce HIV/AIDS in the Liberian military. These arguably serve U.S. strategic objectives directly and successfully, and are thus unobjectionable. Military services, however, also operate at least four separate small programs (especially in comparison to major investments of USAID) supporting civilian health development, all operating with different rules and approvals.^{cviii} These include building or rehabilitating health facilities, arranging for transport of donated medical supplies, donating and arranging for transport of surplus equipment such as generators, and offering training to health personnel. These are all worthy endeavors at some level, and are performed with some coordination with the Ministry of Health and Social Welfare. In the case of construction, the Navy offers the Ministry the opportunity for a construction project, the Ministry identifies a need, and after various approvals through a contracting office in Italy, the Navy hires firms to do design and construction.

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These interventions in Liberia, although time consuming for the ministry, appear benign. They are marginal in their impact and are perhaps best characterized, in the words of a former administrator of humanitarian funds at the Department of Defense, as “random acts of kindness.”^{cxix} But they may not even be benign in having to divert time and attention to priorities and projects that are not its own, and also undermining the power of the ministry to develop its system. Although there is modest consultation with the Ministry of Health and Social Welfare, none of the U.S. military programs are driven by the ministry, providing yet another example of donor determined health activities that are inconsistent with capacity-building strategies that all other donors, including USAID, support. They distract time, attention and resources.

The circumstances in Afghanistan are very different, as there is an active Taliban insurgency in the southern and eastern parts of the country. As noted above, despite the insecurity, the Ministry of Public Health, with donor support from the U.S., the World Bank, and the European Commission, has established a Basic Package of Health Services that has significantly reduced child mortality and is in the process of expanding hospital programs. At the same time, the U.S. military is engaged in a variety of health activities through PRTs and the use of Commander's Emergency Response Program (CERP) funds. These activities have no strategic goals, and the medical staff that administers them has no expertise in health systems development. Despite good faith, there is virtually no coordination, and for logistical reasons almost no communication between military commanders and USAID officials. Medical training program offered by the military, however well intentioned, are ad hoc, without any relationship to priorities of the Ministry of Public Health and civilian human resources development programs. PRTs or other sources of military support operate outside the health reconstruction program operated by the Ministry of Health and are not integrated in any way with its purposes or operations. The aid budgets of PRTs are not accountable in any way to Afghan institutions that U.S. is seeking to support and develop.^{cx} Commanders have funds at their disposal to spend as they see fit irrespective of and sometimes without knowledge of the ministry's plans, goals, or budgets. According to staff of other donor agencies working with ministries of health, military programs may even conflict with national priorities. At the very least, this approach has marginal benefit at costs that are at least double those of equivalent civilian-led projects and at the expense of capacity development.^{cxii} For example, clinics are built that create expectations, but because they

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are not integrated into any system and have no staff to run them, those expectations can go unmet. At worst, they undermine confidence in the government. It is no wonder that some PRT health projects have been described as “bad charity.”^{cxii}

There also exist fundamental differences in goals and values between the national ministry and the U.S. military regarding the specific population to be served by health services. Because health is seen as a way of fighting the insurgency, the military’s strategic goal is to wean the population away from the Taliban. But the minister of health properly sees the legitimacy of his program as dependent on its accessibility to all Afghans, and insists that it serve everyone, including the Taliban. The ministry also seeks to build a base in community engagement in health, which is not a priority for the military.

The existence of military health programs, moreover, can endanger local health workers who participate in them. The Taliban have cut off the noses and ears of Afghans who work at PRT compounds.^{cxiii} But the impact of these programs extends beyond the risk to any workers within military programs themselves. In 2004, the minister of health reported that the presence of PRTs and other international forces engaged in health-related activities endangered local health programs:

[I]t has become increasingly clear that there is a serious security problem in those areas of the country where Provincial Reconstruction Teams, ISAF and/or any other special international military forces get involved in health and health related work, and where aid agencies are also working.

Work by the military or reconstruction teams such as the running of health clinics, the digging of wells and the distributing of leaflets promising aid for information is posing a serious threat to the lives of health workers. The distinction between aid workers and soldiers/reconstruction teams has become fatally blurred.^{cxiv}

In sum, as attractive and benign as a “hearts and minds” approach may be, it is at odds with principles of health reconstruction. Military participation in health activities to win

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hearts and minds cannot be said to advance health reconstruction and may even undermine it for reasons noted above.

3.3 Promoting legitimacy

Another rationale for donor support of health is to establish the legitimacy of the government to its people. Indeed, as World Bank President Robert Zoellick has argued, legitimacy is the “center of gravity” of any strategy and policy to address fragile states.^{cxv} He explained:

Legitimacy in fragile situations is not just achieved through elections or agreements that share power among factions...Legitimacy needs to be earned by delivering basic services, especially visible ones.

This proposition turns out to be complicated as well, with subjective and ‘values’ elements. The subjective element concerns people’s perception of what constitutes legitimate government, and, in this context, whether a government’s ability to provide health services is a demonstration that it can meet people’s needs and warrants their support.^{cxvi} Advancing legitimacy in this sense is thus related to, but less ambitious than, contributing to peace and stability.

The values element is based on principles of social contract and human rights, focusing on principles that should be the basis of the relationship among citizens and social systems.^{cxvii} The notion of legitimacy stresses effective citizen participation, equity, and accountability. In this view, legitimacy is earned by a state not just by perceptions that services are being delivered, but because people have a stake in the delivery of services and a voice in shaping them. Health services are an essential feature of a legitimate state. Thus, Zoellick urges that legitimacy requires local and national ownership, including decision-making power in communities, as well as transparency and accountability, growth equitably distributed, and that development be “backed by a social contract that offers basic health, education, and water services to all.”^{cxviii} A paper from the Organization for Economic Cooperation and Development (OECD) elaborates on the features of the interaction between social contract and legitimacy, emphasizing the expectations a society has of a state, the state’s capacity to provide services and to

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secure revenue for these services, elite willingness to direct state resources to fulfill these expectations, and the existence of political processes to fulfill expectations.^{cxix}

With respect to the “perceptions” prong of legitimacy, there is little research on the degree to which providing health services in post-conflict settings adds to a population’s perception of government legitimacy especially as compared to other actions it takes.^{cxx}

There is likely to be some sense of confidence in government stemming from evidence that a government is offering health services. With government gaining favor in people’s eyes for a “peace dividend” they may be less inclined to join efforts to destroy it.^{cxxi}

There exists some evidence from a county in Liberia that health is a priority for a war-affected population and from Sierra Leone that support for the government did shift with the increasing, and then decreasing, availability of health services.^{cxxii} On the other hand, there are anecdotal reports that the existence of health clinics or service adds nothing to the perception that government is serving its population and even creates a demand for well-equipped local hospitals that may have a less immediate impact on health than primary care.

Just as with hearts and minds approaches, it is also important to identify potential tensions between strategies designed to show immediate impact and those that can develop confidence in the long-run. For example, in seeking to change perceptions, preference can be given to service development designed to gain the support of politically influential groups.^{cxxiii} Other problems can arise as well. Given that increasing state capacity to organize and oversee a comprehensive system of services takes a lot of time, and the results won’t be seen for years, aiming for short-term affirmation by the population can be self-defeating. In Liberia, which as noted above has become an example of post-conflict health development done right, five years after the war ended and two years after the government’s health plan was published, implementation is just getting underway. In a survey taken in a war-affected county, only about one in 20 people thought the health sector was excellent, and only one in 10 thought it was very good. By contrast, almost a third thought it was poor and another quarter thought it was only fair.^{cxxiv}

It may well be that these perceptions change in a few years, once the system is more fully implemented and health indicators show significant improvement, but if the need for

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quick approval is paramount, the tedious process of capacity building may be put aside in favor of piecemeal, visible projects that may be neither effective or sustainable. A gleaming clinic, for example, may be a visible symbol to the population, but less needed to meet the less visible but broader needs of the people than interventions such as improving disease surveillance, improving the safety of childbirth by training birth attendants, assuring primary care, improving the Ministry of Health's ability to manage contracts for basic health services, or rehabilitating existing facilities. Indeed, there have been cases where clinics have been built but there are no health workers to staff them.

While based on values, it would be possible to assess whether health services constructed to contribute to the second dimension of legitimacy. Such studies have not been performed. What can be said is that health services, if structured in ways that reinforce principles of social contract, can be part of the architecture of state legitimacy. Health is increasingly recognized as more than a mere service like electricity, but as a core social institution. It is based on standards derived from universally accepted human rights and international treaties that must be part of any legitimate state, equivalent to a functioning judicial system, and an “essential element of a healthy and equitable society.”^{cxxv} The World Health Organization's Constitution declared that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.”^{cxxvi}

It is increasingly recognized that this right can only be realized through a system of services that is linked to poverty reduction strategies, economic development, attention to social determinants of health such as violence against women and discrimination against marginalized groups, and health determinants that include public infrastructure such as water, sanitation, and disease surveillance.^{cxxvii} The system must be based on standards that include, among others, equity, non-discrimination, quality, participation, transparency and accountability.^{cxxviii} These standards must be built into planning processes and policies, such as strategies for developing a health workforce and water and sanitation systems for assuring that communities have a voice in determining policies and practice.^{cxxix}

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Understanding health through the lens of human dignity requires appreciation of the degree to which social relationships – including inequity, marginalization and discrimination -- contribute dramatically to variations in health, especially among the poor, marginalized, and women.^{cxv} A health system can, on the one hand, reflect or even exacerbate inequities, power differentials, marginalization, and discrimination in society, or on the other hand, it can contribute to their amelioration. Women, especially poor women, often lack the power to make decisions affecting their health, ranging from decisions to seek health care to decisions about spacing of children, both factors that contribute to high maternal mortality ratios. The health system can either reinforce or confront these inequities in many ways. For example, it can require husbands to give permission for their wives to have medical procedures, or it can provide women a place where they can make decisions about their care. Clinic policies can yield to socially embedded forms of discrimination or they can assure that marginalized groups achieve equal access to health services.^{cxvi} It can reinforce differential access to care based on wealth or it can assure that the poor -- who represent the majority of the population after war -- have affordable access to services by eliminating user fees that make access to care unaffordable. It can focus services in urban settings, or it can reduce the gaps in availability of services between rural and urban areas.

These choices matter enormously in post-conflict environments because of the high frequency of human rights violations, including interpersonal violence, social exclusion, and discrimination in the lead up to and during armed conflict. The poor may suffer even less access than before. There is little data on the perceptions communities have about access of the poor to health in post-conflict environments, but a survey in a county in Liberia revealed that 58 percent of respondents thought that the poor do not receive equal treatment in health services.^{cxvii} The exacerbation of social exclusion and discrimination may be why the OECD's Principles of Good International Engagement in Fragile States and Situations includes, as one of its six major principles, respect for human rights. It notes that:

Real or perceived discrimination is associated with fragility and conflict, and can lead to service delivery failures. International interventions in fragile states should consistently promote gender equality, social inclusion and human rights. These are important elements that underpin the relationship between state and citizen,

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and form part of long-term strategies to prevent fragility. Measures to promote the voice and participation of women, youth, minorities and other excluded groups should be included in state-building and service-delivery strategies from the outset.^{cxxxiii}

Indeed, health can be an entry point for a state's effort to address social exclusion.^{cxxxiv} The system of health services also has the potential to play a significant role in addressing other threats to state legitimacy, such as the inability or unwillingness of the justice system to address the legacy of gender-based violence that may continue at high levels well after the conflict ends. The attention to gender-based violence is often considered a problem of law enforcement and gender-specific agencies that focus on norm change. The health system can, however, provide a place where survivors of sexual assault can receive physical examination and counseling, furnish medical certificates for legal purposes where needed, and incorporate prevention of gender based violence in community-based educational activities. Again, while there is no evidence one way or the other, and more research is warranted on this question, it may well be that health systems development may promote legitimacy by creating perceptions of state competence in fulfilling its service obligations.

Similarly, because it affects every community, a health system can reinforce practices central to legitimacy by assuring that communities have a voice in the planning and ongoing oversight of key services and an effective means to hold both local providers and governments accountable for performance. At the same time, one of the challenges in health is that the asymmetry of information between citizens and providers is much greater than in water services or primary education. It is not easy to bridge this without very clearly constructed mechanisms for accountability. Robust efforts to overcome that disparity not only respect the rights of the people, but also give them a stake in the larger system by fostering familiarity with responsibilities and rights of citizenship at the community level, and can enhance confidence in government.^{cxxxv}

By enhancing participation, the health system can in fact become a vehicle for civic engagement.^{cxxxvi} Participation can reinforce a sense of empowerment that can have far-reaching impacts on the legitimacy of the new state even as it improves the quality of health services.^{cxxxvii} Thus, there is general recognition that the creation and

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administration of a health system is intimately connected to the quality of governance, including civil society participation and the protection of marginalized groups. The U.S. action plan on harmonization, submitted to the Third High Level Forum on Aid Effectiveness held in Accra, Ghana in 2008, thus stressed that the U.S. is committed to state capacity building that promotes accountability through support for advocacy groups, professional organizations and civil society groups.^{cxviii}

Viewing legitimacy from this broader perspective has, like other policy approaches, significant and substantive process implications for planning, financing, and implementing post-conflict health reconstruction. It clearly requires a systems approach based on ministry leadership, must be committed to equity and quality, demands that post-conflict health initiatives include linkages to other programs promoting non-discrimination, gender equality, and reduction of gender violence, and must include mechanisms for community participation and accountability.^{cxix} It is also congruent with principles of health reconstruction.

Seen in this way, promoting legitimacy brings instrumental rationales for engagement in post-conflict health reconstruction full circle. It turns out that support for health development in the regions of the world where suffering is so high can, if done properly, also help achieve other goals, including supporting the emergence of legitimate states. Moreover, incorporating ideas of equity, participation and accountability, ending marginalization, and recognizing how these can contribute to a more decent society actually add depth to what we mean by the intrinsic value of health. An approach based on legitimacy also reflects the insight of Amartya Sen, on the connections among political freedom, economic development, sound social institutions, and long-term societal well-being.^{cxli} It affirms that health systems can play a role in both promoting individual well-being and resolving underlying inequities by giving everyone a stake in it. At the same time, investing in health as a means of furthering emerging state legitimacy does advance core U.S. interests in a more peaceful world in the same way that supporting the rule of law and democracy does in creating an essential foundational element of a well-governed state, and through that, increases the likelihood of long-term peace and stability. The reverse is also true: health reconstruction done badly can equally serve to reinforce inequity, alienate communities from government, and reduce the legitimacy and potential long-term stability of the state.^{cxlii}

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In sum, health system reconstruction is a long-term project that has the potential to advance legitimacy, not just because of the creation of services, important as those are. It can strengthen state capacity and serve as a means of contributing, in very concrete and immediate ways, to the amelioration of inequities and inequalities in society. And it can provide people an opportunity to participate and take ownership as responsible citizens in the structure and content of the system. Health systems can thus be powerfully reinforcing aspects of legitimacy relating to governance, human rights, and the rule of law.^{cxlii}

4. Implications for Refashioning U.S. Foreign Assistance Programs

Based on this analysis, U.S. policy on post-conflict health reconstruction, and the programs to implement it, should be based on six premises:

1. Donors, including the United States, should support governments emerging from armed conflict in addressing the extraordinarily deleterious health consequences of war, the destruction of health infrastructure, and loss of health personnel;
2. Health is a core social institution and a health system that operates according to principles of equity of availability access, non-discrimination, participation, transparency, and quality enhances the legitimacy of the emerging government, the prospect of future economic development, and long-term stability;
3. When governance circumstances permit, the host government, through its ministry of health, should lead the process of planning and stewardship;
4. Community and civil society engagement in planning, monitoring and accountability can both bring about a stronger and more responsive health system and can contribute to the amelioration of inequity, marginalization and discrimination;
5. The role of donors and technical experts is first, to provide intensive financial and technical assistance to build the capacity and skill of the ministry of health to lead the development and implementation of policies and plans for effective health systems and second, to support the costs of implementation and interim services;
6. Development of health systems in post-conflict settings is a complex process that requires donor commitments that begin early, last for many years, and are flexible and tailored to local needs for training, supervision, mentoring, and support.

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These premises should result in a policy of funding post-conflict health reconstruction as a high priority in the U.S. global health systems strengthening and fragile states agenda. The policy is not based on the idea that health is as likely to bring about peace and security in the short and intermediate term, though it may contribute in modest ways to this goal. To gain resources and political traction, the temptation to characterize health as a security concern is strong, especially in the context of post-conflict interventions, where security, governance, and rule of law concerns are recognized as paramount.^{cxliii} But in view of the absence of evidence that health significantly improves short-term security (and the consequent skepticism among policymakers faced with the claim), and the distinct possibility that security-based approach will skew health interventions, the temptation should be resisted. Similarly, consistent with the Institute of Medicine’s approach, while the goal of enhancing the U.S. security and diplomatic interests can be a basis for providing resources and technical assistance for health services development in poor countries, funding should not be dependent on showing that aid for health development in a particular case needs to advance the image or strategic interests of the U.S.^{cxliv}

Once the overarching policy is established, foreign assistance programs should be adjusted to carry out the objectives of the policy. These include:

1. Building system capacity through leadership, skills developing and authority;
2. Creating flexible funding mechanisms that support capacity development and ensure concurrent service delivery;
3. Committing to community participation, accountability, and determinants of health; and
4. Limiting the role of the military in health reconstruction in the civilian sector.

4.1. Capacity building: Support system capacity building through leadership, skills development, and authority in the ministry of health

Consistent with the Paris Declaration and Accra Agenda for Action, the U.S. should support and adopt aid mechanisms so that they can effectively contribute to building state capacity for a comprehensive system of health services.^{cxlv} This includes strengthening the ability of government, through its ministry of health, to establish policy and strategy, to set priorities to meet system needs, and to implement them. Capacity

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building begins with supporting leadership in the ministry of health to provide vision and strategy, develop managerial competence, garner support from the state's political leaders, demonstrate a willingness to fight corruption, attract dedicated staff to carry out the mandate, and exhibit a combination of openness to community and civil society participation and decisiveness to move plans forward. Policy should support the development of technical knowledge in service design, procurement and contract management (especially where NGOs will be providing services), health information systems, human resource capacity development, financing, and monitoring and evaluation. Policy should also be linked to human rights standards including equity, non-discrimination, quality, community participation, accountability, as well as to addressing gender based violence and social marginalization. Capacity building should of course extend to the local level, where services are delivered. These capacity building activities need to take place simultaneously with the expansion of services.

As important, capacity building must be accompanied by a willingness to yield decision-making control and credit to the local authorities, accompanied by appropriate forms of financial accountability to donors. Acquisition of skills sets in all the dimensions of health system development will not yield results if the ministry of health lacks authority to exercise them. This should extend even to technical assistance. The U.S can send an important signal about the seriousness of support for state-building if it provides the ministry with financial support for bringing in technical experts rather than have them sent by the U.S. under the model of the Office of the Coordinator of Reconstruction and Stabilization. However benign and supportive the provision of technical experts may be, ministries will be more empowered by receiving resources to hire consultants. Policies designed to limit corruption and promote accountability, often accompanied by traditions of tight controls on aid, though grounded in legitimate concerns, must be fashioned to support ministries to exercise the power of decision-making that is essential for legitimacy.^{cxlvi}

This approach also requires policies that enable the state to take credit for services and other elements of implementation of its health plans. Even while purporting to enhance the confidence of people in the ability of their own governments, U.S. practice undermines that objective by requiring that clinics, vehicles, and other objects be

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festooned with required signs that these are gifts from the American people. The ‘do no harm’ principle applies well.

In some circumstances, of course, deficiencies in leadership, competence, or commitment, or the existence of corruption provide grounds for avoiding deference to ministries. In these cases, building systems from the local or district level may be an alternative, and where basic criteria for sound governance are not met, NGOs will have to be in the lead. In all cases, there should be clarity about the roles of NGOs. Even in places where a government is emerging that meets criteria for representativeness, respect for the rule of law and other indicia of good governance, NGOs will often be needed as true partners to run services in the short-term (and in some places in the intermediate and long-term, too). In these cases, ministries should still set policy, establish service priorities, and engage in regulatory activities so that legitimacy accrues to the ministry rather than to the NGOs.^{cxlvii} During the emergency phase, NGOs typically must act independently of government in order to meet urgent medical needs, and often lack either the mission or the competence to support local health service capacity development. Moreover, as noted above, to maintain neutrality, NGOs often need to avoid identification with the government “side.” But in the health systems development phase, capacity building requires alignment with and deference to government whenever possible. This is difficult even when NGOs act under government contracts, since they have independent sources of funding to set their own priorities and operate their own programs. Donors can at least avoid exacerbating the problem by channeling funds through ministries rather than through direct contracts with NGOs wherever possible, as is being done in Afghanistan. This course carries challenges of its own in requiring capacity of ministries to administer contracts and to address corruption, which can often result in delays and sometimes prove insurmountable. But the challenges should not result in taking the path of least resistance as a matter of policy. Finally, while NGOs can be effective in acting as contractors for services, there is inevitably tension in asking them to train and empower local entities to take over these responsibilities in the long term. One way of ameliorating that concern is to ensure that their performance is measured by criteria relating to capacity development as well as service delivery.

Finally, support for ministries of health needs to be accompanied by linkages to other ministries with responsibilities affecting the success of health development, including

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finance, education, agriculture, animal health, infrastructure, water resources, transport and justice. The uniqueness and complexities of health reconstruction, however, deserve special and independent attention to the ministry of health and in some circumstances, even financing mechanisms tailored to the needs of the ministry.

4.2 Funding Mechanisms: Create flexible funding mechanisms that support capacity development and service

Funding streams should follow principles of harmonization and alignment to foster a coherent and flexible approach to post-conflict reconstruction in health. This approach is especially difficult in the current health funding environment not only because of differing donor priorities and mechanisms, but because the majority of global health funds come from vertical programs for HIV/AIDS, malaria and tuberculosis. Aid for post-conflict reconstruction should be set up to have the flexibility to give support to systems development and to meet local needs. Additionally, a variety of aid mechanisms such as multi-donor trusts and budget support should be available if they would meet the ministry's plans and can be appropriately administered. Put another way, the needs for health systems development should drive U.S. funding mechanisms for health reconstruction, not, as so often happens, the other way around.^{cxlviii}

This approach requires flexible funding mechanisms that can support ministry priorities under its policy and strategy, as long as they meet standards of equity and human rights, and are coordinated with other donors. The mechanisms should be capable, if needed, of funding recurrent expenses like salaries, capital costs for clinic rehabilitation, technical assistance, and direct support for ministry budgets through pool funds or multi-donor funds (such as the World Bank's Post-Conflict Fund or through USAID support for the Afghanistan Ministry of Public Health) rather than channeling aid directly through NGOs or private contractors. Existing major health programs, including the U.S. global HIV/AIDS and malaria initiatives, as well as health initiatives of the Millennium Challenge Corporation, will likely remain a major source of funding, so need to be well coordinated with a post-conflict reconstruction program. Reporting and accountability mechanisms to assure financial and program integrity should be consistent with capacity building objectives. For example, outcomes measures that focus on particular projects rather than system-building goals may not be appropriate.

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Support for capacity building should begin at the earliest possible time, even before the conflict has ended, if that is feasible. More generally, emergency response should be structured to support capacity development, services (including salaries), and systems development.

Current funding policies within USAID hinder the ability to carry out these strategies efficiently, or sometimes at all, because of preferences for project-based funding, primary reliance on funding through NGOs or private contractors, reporting requirements, and reluctance to fund governments, especially for recurrent costs. As one minister of health put it, “Donors talk about health as a means to increase legitimacy of the government in the eyes of the people, but the way they provide resources undermines legitimacy.”^{cxlix} In some countries, special arrangements have been made to circumvent these restrictions; instead, the aid programs should be restructured to avoid the need for work-arounds.

Additionally, U.S. emergency assistance programs are not designed to, and in certain instances, lack the authority to make the early commitments needed to foster capacity and health systems development during the emergency phase. The Office of Foreign Disaster Assistance in USAID (OFDA) operates with great flexibility in providing resources to meet emergency humanitarian needs, mostly channeled through NGOs. But it has no mandate for development-related and capacity building activities or long-term commitments. Similarly, the State Department’s Bureau of Population, Refugees and Migration, while having the authority to ask its recipient organizations to include transition strategies, has a mission for emergencies and a short funding horizon. On the development side, USAID’s limitations on what activities may be funded impede carrying through on plans. In Southern Sudan, for example, while the ministry of health has a national plan and strategy, it suffers from a severe shortage of resources to pay health workers. Yet donors restrict the ability of the ministry to use aid funds to pay health workers.^{cl}

Given a much strengthened mandate and authority, combined with the right leadership and additional resources, USAID could carry out the policy objectives set out in this proposal. USAID has been severely weakened over the past generation, to the point

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where it only administers a small fraction of U.S. global health funding, and some observers do not see it as having potential for leadership in the future. But it has experience and some notable successes in post-conflict reconstruction, and these responses could be improved if funding mechanisms were more flexible and leadership and authority were enhanced. Additionally, its humanitarian emergency arm, OFDA, could be provided greater authority and sufficient resources to support early engagement in health systems development, especially given that many NGOs in health have both relief and development capabilities. Its expertise could be enhanced through greater staffing and linkages with development arms of USAID. Funding models along these lines exist, such as the European Commission Humanitarian Plus Program, which strives to link the transition from relief to development even as it provides humanitarian aid.

To achieve these goals, USAID would have to expand its expertise in the field and yield greater control over programs to recipient governments. And its global health program and regional offices should collaborate with OFDA and BPRM so they can provide expertise in addressing the complexities of post-conflict health systems development at the earliest possible time, coordinate with the State Department and National Security Council, and assure seamless response.

Finally, from the start, even given the annual appropriations process, the expectation should be that these investments would continue over a very long period of time. The idea of providing intensive, short-term support for post-conflict interventions is very appealing and is central to the approach taken by the State Department Office for Coordination of Reconstruction and Stabilization, which when established envisioned two-three year commitments. Such short time frames are often justified by the need to encourage sustainability while implementing the use of a civilian reserve corps that provides guidance and technical assistance. But all too often sustainability in the financial sense takes precedent over the technical and political sustainability, which determine success in the long run.^{clii} In many countries, short-term financial sustainability is simply impossible even with reasonable economic growth, and the likelihood of long-term success will be much enhanced if the up-front commitment is sufficiently extended to allow the economy to develop to support the system.

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4.3 Community Participation and Accountability: Committing to community participation and accountability mechanisms

The weakest element of health systems development is typically community and civil society participation in development and oversight.^{clii} Assuring participation is a complex undertaking, but is essential to address issues of equity, discrimination, and quality, to give citizens a stake in the system, and to have mechanisms to hold service providers and local and national officials accountable for their performance. In some cases, communities are consulted as health plans are developed, but their influence quickly fades. In other instances, community engagement is not about participation in governance, but in service delivery and behavior change, equated with developing roles for, and payment of, community health workers. Given the need to build legitimacy, and concerns about equity, quality, and non-discrimination, commitments to community engagement and funding for the costs of facilitating community involvement should be enhanced and built into health development aid programs as an essential component.

Accountability mechanisms should also be part of the development process, not only because they are empowering and are an element of social contract essential to legitimacy, but because they are necessary to strengthen services. This is especially needed where achieving numerical targets can interfere with the need for institutional reforms and capacity building. These mechanisms include not only those available through the formal political process, but those focused specifically on both local providers and ministry.^{cliii} Also, consideration should be given to funding civil society organizations charged specifically with monitoring and advocacy so that accountability is more than a matter of filing reports.

These mechanisms are reinforcing. Community outreach helps people better understand and articulate what they should want, expect, and demand in terms of health services, which in turn can lead to greater responsiveness from the ministry of health and improved health services.

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4.4 The Role of the Military: Limiting the role of the military in civilian health reconstruction to programs that rely on its logistical capacity, and transferring resources for health development to civilian agencies

The U.S. military sometimes plays an important role in logistics for delivery of humanitarian aid in disasters and in supporting the health of national military forces through training, facility and program development and health promotion programs.^{cliv} Additionally, in combat operations or occupation it can (and in some cases is obliged to under international humanitarian law) provide care to wounded or sick civilians or supply or provide other forms of humanitarian support to local health facilities and administrators that civilian agencies cannot reach. But a firm line should be drawn to restrict military roles in development activities in the civilian health sector either in war or in post-conflict settings. The only exceptions should be in circumstances where the military has a unique skill to add, where its services are specifically requested by ministries of health in conjunction with civilian U.S. agencies, and where it can act without jeopardizing the safety of health workers and NGOs. Peacetime interventions such as drilling wells, building clinics, and training health workers should be left to civilian agencies.

To carry out such a policy, the Department of Defense would no longer seek to integrate health reconstruction activities into its stability operations unless there are compelling exceptions sought by a legitimate host government. This change carries significant budgetary implications. Congress should redirect funds for health development now channeled through the Department of Defense, other than those allocated to health assistance to foreign military organizations and for the costs of transfer of surplus equipment, to USAID for health development activities in post conflict countries and fragile states.

5. Conclusion

There are compelling reasons to include a commitment to post-conflict health reconstruction as a priority for U.S. global health systems development and fragile states policy. Carrying out such a commitment can alleviate the horrific and abiding health consequences of war, contribute to the emergence of legitimate states and promote

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equity and non-discrimination in places where they have been most deeply infringed. Policymakers should resist, however, highly seductive appeals to ground policies on health reconstruction to achieve short-term peace and security or as a diplomatic strategy to win favor with populations in states emerging from war. Not only is the rationale for such policies weak but relying on them can distort the interventions supported in ways that undermine success.

To implement an effective policy of health systems development in the aftermath of war, foreign assistance programs will have to be restructured to follow principles of health reconstruction in post-conflict states that have emerged from the experience of the last two decades. Agencies with the greatest knowledge in global health should take the lead and support nascent or revived ministries of health in strategies to design and build comprehensive and accountable health systems. The shifts required are not radical ones, and there are good models both for aid mechanisms and development strategies to meet on which to draw. The more thoroughgoing challenge, rather, is making the required commitments.

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