HEALTH POLICY FORMULATION IN COMPLEX POLITICAL EMERGENCIES AND POST-CONFLICT COUNTRIES

A LITERATURE REVIEW

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DISCLAIMER AND CONFLICT OF INTEREST

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EXECUTIVE SUMMARY

This literature review was requested by the WHO/EHA to examine current knowledge about health policy formulation in post-conflict countries and complex political emergencies. According to the literature reviewed, health policy formulation in post-conflict countries and complex political emergencies has been successful in providing useful direction to health service providers, and channelling donor resources in a more effective manner. Based on this success, there may be scope to expand health policy formulation and implementation in both post-conflict countries and complex political emergencies to address the fragmented, and often sub-effective provision of health services found in these countries.

During a complex political emergency, health systems are often severely compromised, and health policy formulation is disrupted. Health needs increase, along with morbidity and mortality rates, and humanitarian actors often enter the arena to provide essential services that the government is no longer willing or able to provide. Although some inter-agency co-ordination takes place, it is rare that a joint health policy and strategy framework is developed to guide the various agencies in their activities. This lack of policy frequently leads to a patchwork of activities, with different agencies using different strategies and health care models. In addition, health authorities do not have the capacity to monitor and guide the various activities, nor is there a single agency with the tools, resources and authority to take up this role. It is suggested that this lack of co-ordination and policy vision lead to inefficient use of limited human and financial resources, and results in less effective health services and increased morbidity and mortality.

In order to alleviate these problems, numerous authors have suggested supporting the health policy formulation process and the creation of health policy frameworks. This can be done via aid coordination mechanisms such as sector-wide approaches, performance-based partnership agreements, and consolidated appeals processes. Some countries have created country-specific mechanisms that focus on the creation of health policy frameworks.

Policy frameworks can be described as systemic, where basic objectives or principles of the health system are decided, and programmatic, where intervention priorities are set and translated into operational guidelines for service delivery. In post-conflict countries, experience has shown that systemic and programmatic policy formulation has proved useful in guiding rehabilitation and reform. In Kosovo, for example, a systemic interim health policy was developed that appears to have been successful in setting the future framework for a reformed health sector, and in channelling large amounts of donor funds into these reforms. In complex emergencies, the effectiveness of health policy frameworks remains untested, although experience from Somalia shows that such frameworks are useful to humanitarian agencies and donors as they provide policy guidance and promote a co-ordinated approach.

Policy formulation in complex political emergencies is complicated as there is no legitimate government to take control of the policy process, which includes agenda setting, policy design and implementation. Thus, the question arises as to which of the multitude of humanitarian and political actors, none of which have authority over the others, should take part in, and/or lead the policy process. Questions as to the

role of health policy in complex emergencies, and the effectiveness of the policy process remain unanswered and require further research.

Based on experiences found in the literature, health policy formulation in both types of settings should be made more inclusive and collaborative, and issues of legitimacy should be explicitly addressed. In some cases, the creation of a lead policy actor, for example the Somali Aid Co-ordination Body, was found to be useful. Strong donor support for health policy formulation is necessary in order to ensure its implementation.

Eight recommendations for post-conflict rehabilitation of the health sector that are found from a study on Afghanistan include: [(1)]

- Outline policy directions early in the post-conflict transition to set guidelines for initial rebuilding, and create a vision for the future.
- Differentiate different policy "streams" into fast- and slow-track policies to meet both immediate and long-term needs.
- Provide technical expertise in policy development to the health sector through committed staff and resources.
- Focus on creating health policies at the health system level.
- Do not rebuild the old health system as there is a new social, political, economic and cultural milieu and the conflict has enforced and/or created geographic and social inequities.
- Ensure adequate ownership and consultation over the policy process to build capacity and generate commitment to the policy process and individual policies.
- Link coordination to resource allocation to facilitate decisions-making, prioritisation and implementation.
- manage information proactively, ensuring that information is gathered, analysed and disseminated to relevant people.

Many of these lessons could also be applied to ongoing complex political emergencies, however there has been so little research on policy processes in complex political emergencies that it is difficult to create a substantive list of lessons learned.

Overall, health policy frameworks appear to have the potential to improve health care provision, enhance aid co-ordination, and maximise the effects of humanitarian aid. Thus, there is a need for more operational research and piloting of approaches that will help in the formulation and implementation of health policy frameworks in complex political emergencies and post-conflict settings.

[(1)] Extracted from Bower. 2002. Reconstructing Afghanistan's health system: Are lessons being learned from the past? LSHTM.

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LIST OF ACRONYMS

CAPs	Consolidated Appeals Process
CHAPs	Common Humanitarian Action Plans
CPE	Complex political emergencies
DRC	Democratic Republic of Congo
EHA	Emergency and Humanitarian Action
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced People
MoH	Ministry of Health
MoPH	Ministry of Public Health
NGO	Non-governmental organisations
OECD	Organisation for Economic Co-operation and Development
PPAs	Performance-based Partnership Agreements
SFA	Strategic Framework for Afghanistan
SWAps	Sector-wide approaches
UN	United Nations
UNSMA	United Nations Special Mission to Afghanistan
WHO	World Health Organisation

INTRODUCTION

There is increasing recognition that the humanitarian aid system needs to be strengthened in order to improve its impact on vulnerable populations caught up in complex political emergencies.[1] One means proposed is to bolster health policy processes, and the development of health policy frameworks to guide humanitarian actors in providing health services.[2] This literature review was commissioned by the WHO's Emergency and Humanitarian Action (EHA) Department to determine the extent of knowledge about health policy formulation in complex political emergencies and post-conflict countries.

In complex political emergencies, weak epidemiological, social and political analyses, combined with different mandates, perceptions and values of organisations, often result in incoherent, fragmented health responses. It is proposed that improved health policy formulation will lead to more co-ordinated and effective health service provision, and decrease excess morbidity and mortality. Improved policy formulation may also facilitate the early phase of a country's transition to post-conflict. The transition between post-conflict and complex emergencies is a fluid one, and countries sometimes oscillate between the two phases when power structures remain weak. Once a country has moved into a stable post-conflict phase, policy-makers should broaden their perspective and focus on the creation of a sustainable health system.

In addition to supporting health policy processes, two other means to strengthen the humanitarian system will be examined in this document, [(2)] [3] both of which have implications for health policy formulation. First, initiatives are on-going to improve aid co-ordination mechanisms (such as the consolidated appeals process and sector-wide approaches) in order to improve needs assessments, prioritisation of health services, and the creation of strategies to guide the allocation of funding.[4] New contracting mechanisms are also being developed, such as performance-based partnership agreements, which can be loosely classified as a new type of aid coordination mechanism. Second, there have been calls for research to strengthen the evidence-base of health interventions for dispersed populations in complex political emergencies. Such research is currently lacking, and is vital in providing an improved evidence-base for health policy formulation.[5]

This literature review investigates current knowledge about the formulation of health policy frameworks and the processes that are used to develop them in post-conflict countries and complex political emergencies, and explores whether they have proved useful in guiding the multitude of health sector actors. The first section begins with a brief overview of complex political emergencies and their impact on health and health systems. It then describes some of the challenges faced by organisations working in complex political emergencies and post-conflict countries, and summarises some of the lessons learned. The second section focuses on issues of health policy formulation in chronic complex

(2) Other suggestions to improving humanitarian aid, besides improving aid coordination mechanisms and stimulating health policy processes include improved standards, as laid out in guidelines such as Sphere and the Humanitarian Accountability project, and the introduction of logical frameworks and evaluations to assess performance. Quality management models that institutionalize learning, and self-regulation rather than accreditation by donors may also prove to be the way forward. Finally, more evaluations of system-wide performance, such as the Interagency Rwanda study, need to be developed to assess the influence and activities of the various political, donor, and humanitarian actors (see endnote 3).

emergencies and post-conflict countries. It provides an overview of the nature of health policy, and describes how conflict impacts on the formulation and implementation of health policy. The third section describes the need for research on health policy processes and on current public health interventions. The final part of the document concludes with discussion and recommendations for supporting the health policy process in both complex political emergencies and post-conflict countries.

COMPLEX POLITICAL EMERGENCIES AND POST-CONFLICT COUNTRIES

THE NATURE OF COMPLEX POLITICAL EMERGENCIES

Complex political emergencies have been defined as conflicts that have all, or many of the following characteristics:[6] [7]

- The conflict is often within and across state boundaries, as opposed to being purely inter- or intra-state (as opposed to wars, which are normally inter-state).
- The conflict is often protracted for many years.
- There is a collapse of state functions and structures (institutional collapse)
- Violence is directed towards civilians and civil structures
- There are many social cleavages between groups, many of whom are exploitative, predatory and are mobilised and manipulated by those who seek political and economic power and resources, as well as more basic needs such as security.
- There is an absence of normal accountability mechanisms due to lack of legitimate governance.

As of 2000, there were approximately 30 active conflicts, and almost all were in less developed countries.[8] The following table lists some current complex political emergencies and post-conflict countries.[9]

Africa (1)	Africa (2)	Europe	America	Middle East	Asia
Angola + Burundi * C.A. Republic + Chad + Congo + D.R. Congo * Djibouti + Eritrea + Ethiopia + Guinea Bissau + Liberia *	Mali + Mozambique + Namibia + Niger + Rwanda + Sierra Leone + Somalia * South Africa + Sudan * Uganda +	Armenia + Azerbaijan + Bosnia + Croatia + Georgia + Former Yugoslav Republics of Macedonia and Kosova + Former Yugloslav Republic + Russian Federation of Chechnya *	Columbia * El Salvador + Guatemala + Haiti + Nicaragua + Peru +	Algeria */+ Lebanon + West Bank * Yemen + Iraq +	Afghanistan+ Cambodia + DPR Korea * East Timor + Indonesia (Malukus) * Sri Lanka * Tajikistan *

Source: United Nations, World Bank, OECD, OCHA, Reliefweb
*+Countries emerging from violence (post-conflict) *Countries experiencing violence and conflict*

The nature of conflict has been explored by various disciplines including economics[10], health [11] [12] development studies[13] and political economics.[14] [15] Various causes of conflict that have been proposed include political and economic

marginalisation and inequality leading to grievance, economic stagnation, heavy state intervention, presence of valuable commodities, environmental degradation, low levels of education (especially of young men), and the politicisation of ethnicity.[16]

In addition, many complex political emergencies began as cold war proxies - for example Angola, Mozambique, Nicaragua, and Afghanistan.[17] The end of the Cold War in 1990 signalled a change in the nature of these wars.

> "… conflict has become identified less with the process of state formation, the common theme of an earlier generation of ideologically–motivated nationalist and revolutionary struggles. Rather, conflict is associated increasingly with a process of state disintegration, where the quest for power is linked to the economic and political ambitions of armed groups, not to the achievement of a clearly articulated socio-political agenda."[18]

Complex political emergencies can be divided into two categories – ideological, state-centred wars such as Eritrea and Nicaragua, and privatized, resource conflicts which are extractive and exploitive in nature, such as the Democratic Republic of Congo (DRC). These two categorizations are not mutually exclusive - fragmentation can occur in an ideological war (S. Sudan) and *vice-versa* - however usually one motivation will remain prominent. This affects the mechanisms used for conflict resolution – for example, in resource wars, it is important to confront groups with economic interests, and create financial incentives for peace.[19]

The nature of the complex political emergency also affects the provision of health services and the ease of the post-conflict transition. In more ideological conflicts, state infrastructure and capabilities are weakened, but their functions are generally maintained to some degree. In resource conflicts, state structures are more likely to collapse, as has happened in Somalia, the DRC and Afghanistan. This has implications for organisations that are left to provide services during the emergency, and for rebuilding public sector services in post-conflict countries.[20]

IMPACT ON HEALTH INDICATORS AND HEALTH SYSTEMS

Complex political emergencies are known to have a negative impact on social and economic conditions[21] and health indicators in general, [22] [23] [24] [25] as detailed in case studies of Ethiopia[26],[27] El Salvador[28], Democratic Republic of Congo[29] [30], Uganda[31] [32], Kosovo[33] and Iraq.[34] It is estimated that the number of direct deaths attributable to violence is increasing, such that by 2020, war will rank 8th in the global burden of disease league tables, alongside HIV/AIDs, tuberculosis and malaria. [35] [36]

The global evidence base upon which these predictions are based is limited by the lack of epidemiological data on the direct and indirect effects(3) of conflict on health. This dearth of data is due to methodological shortcomings, restricted access to populations, and breakdown in health information systems during conflict.

(3) There are various definitions of direct and indirect deaths. Murray defines direct effects as combat deaths, and indirect deaths "as the number of deaths following a war minus the number of deaths that would have occurred in the same period if the war had not occurred" (2002 Ibid). Direct impact has also been defined as deaths, injury, disability and the destruction of the health services, and indirect impact, as, for example, the erosion of innovative health policies in favour of increasing military expenditure (Zwi and Ugalde, 1989 Ibid).

[37] [38] [39] Recent work shows that it is possible to determine direct deaths from conflict using demographic analyses or indirect mortality measurements, however, it is more difficult to measure indirect deaths leading to under-estimation in many cases.[40]

The impact of complex political emergencies on public health systems has been documented in some detail.[41] [42] [43] [44] Health systems have been defined by the 2000 World Health Report as

> "comprising all the organizations, institutions and resources that are devoted to procuring health actions. A health action is defined as any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health."[45]

The main impacts on public health systems are outlined in Table 1, and can be classified as follows: a substantial decrease in amount of resources, large changes in the management and organisation of health services, and the evolution of different modes of delivery.[46] The impacts on private health provision and traditional medicine are not well-documented.[47]

Table 1 – Impacts of Conflict on Health Systems[48]

Limited Resource Availability:

Financial
- Diversion of resources to military
- Reduced revenue
- Reduced control over funds
- Increased dependence on aid

Health workers
- Injured, killed and kidnapped
- Displaced to urban areas/out of country
- Disrupted training/supervision
- Poor morale
- Poorly paid, if at all

Equipment and supplies
- Lack of drugs / maintenance
- Reduced access to technologies
- Inability to maintain cold chain

Service infrastructure
- Destruction of clinics
- Disrupted referral and communication

Management and Organisation of Health Services
- Diversion from development based programs
- More centralised, urban-based, vertical programmes
- Disruption of complex programmes
- Focus on the short term
- Limited scope for consultation
- Reduction in data for decision-making
- Limited management training
- Reduced ability to monitor funds and resources
- Increased fragmentation

Changes in Service Delivery
- Shift from primary to secondary care
- Urbanisation of provision
- Decreased activity in periphery
- Disrupted campaigns, health promotion, disease control, outreach
- Reduced access and utilisation: fear, curfews, landmines, charges
- Increased private provision

CHALLENGES TO WORKING IN COMPLEX POLITICAL EMERGENCIES

Health care provision in complex political emergencies is a difficult task. Due to the collapse of the state, international organisations, including bi-lateral and multi-lateral donors, non-governmental organisations (NGOs) and the UN intercede to provide essential health services. Services provided are often of three types: health services in refugee and internally displaced persons (IDP) camps, control of epidemics, and primary health care for vulnerable, war-affected populations.[49]

Challenges for health service delivery include how to prioritise, implement and co-ordinate service provision, taking into account issues of equity and limited access.[50] For dispersed populations, the problems are even more profound, and include: limited access to ill-defined and insecure regions; very limited household and financial assets; and difficulty in targeting assistance, made more complicated by pre-existing government services.

Agencies must also learn to navigate donor relief, rehabilitation and development funding lines based on ideological constructs (for example, the often-criticised relief to development continuum)[51] that are often disconnected from political reality.[52] In addition, donors provide inappropriate funding lines. For example, in Sudan, donors shifted to development aid, despite the fact that the minimum requirements for this type of aid – improved security, human rights and access, empirical evidence that the emergency is over, and a legitimate government – were not in place.[53]

Another challenge to working in conflict is collaborating with remaining national authorities - whether it be the Ministry of Health[54] [55] [56]and/or rebel forces[57] - to provide minimal health care services. Engagement with these actors is made more complex, both in terms of politics and in terms of aid co-ordination, due to questions regarding these actors' legitimacy and authority. For example, in South Sudan, the challenge lay in liaising with various rebel groups and the Khartoum government to negotiate access to vulnerable populations.[58]

In some complex political emergencies - most usually wars of liberation (for example Eritrea,[59] Tigray,[60] and El Salvador[61] - rebel groups create a primary health care system to provide necessary services to the war-wounded, and also to gain the support of the populace. The challenge then becomes how to work with these authorities, and to support appropriate aspects of this health "system." Once the conflict ends, health planners need to examine how best to incorporate these (rebel) systems into the new government's health system.[62] For example, in Mozambique from 1989-1995,

> "service provision in RENAMO-controlled areas was high on the agenda of many donor agencies. Despite mutual distrust and occasional incidents, both parties allowed NGOs to revive services in these areas: the political significance of the indirect collaboration between hostile sides was remarkable. Often, health services were the first signs of the coming normalisation of civil life. A comprehensive programme to retrain RENAMO health workers and to re-integrate them within the national health service was implemented, defusing a cause of tension and showing the MoH's willingness to process on the reconciliation path. RENAMO came to accept health workers from the government side to staff health facilities in their own areas. The whole process powerfully contributed to the progressive reintegration of rebel areas into a common administration."[63]

Finally, there is on-going debate regarding whether international humanitarian assistance can support efforts to promote conflict prevention and peace-building. Many authors have argued that humanitarian aid, and in particular health initiatives, can be used to build peace and prevent conflict.[64] [65] [66][67] However, some have argued that such initiatives are based more on ideology than on evidence.[68] For example, one study found that donors and organisations often lacked the contextual

knowledge and skills to be effective in this process, and that they found it difficult to engage with a state when it was party to the conflict.[69] Also, it has been argued that local NGOs, which are the best placed for peace-building, are often insufficiently supported by the humanitarian system, and so peace-building is constrained.[70]

POST-CONFLICT COUNTRIES

After a complex political emergency has ended, countries are classified as post-conflict. Post-conflict countries have been defined as having four characteristics: 1) the signing of a formal peace agreement; 2) a process of political transition by elections, military or civilian coups 3) increased levels of security and 4) a perception among national and international actors that there is an opportunity for peace and recovery.[71] Not all of these factors must be present simultaneously. For example, a peace accord may not be signed if there is a coup, as happened in Uganda in 1986 and Ethiopia in 1999.[72] Also, post-conflict countries can be highly unstable, and some countries, such as Angola, Liberia and the Democratic Republic of Congo, repeatedly cycle between peace and war.[73]

Post-conflict countries often have the following features. The infrastructure (i.e. roads, communications, health centres, schools) has usually been damaged, with large economic and social consequences. The economy is structurally distorted with high military spending, a greatly reduced tax base, and a very developed, informal (and often illegally-based) economic system. The social fabric has also been disturbed - communities are often dispersed, civil society is fragmented, and the means for violence are still in place. The legitimacy and legal status of the government (Afghanistan) and/or interim UN 'government' (Cambodia, Kosovo) is uncertain, especially during transitional periods to democratic systems. The public administration is also limited in its capacity to provide a policy framework, mobilise and allocate resources, organise and regulate services, and absorb funds.[74]

Within this context, there is often a large influx of funds to stimulate post-conflict reconstruction. While this presents many opportunities, it can also pose problems due to the low absorptive capacity of the government. Some international organizations have defined policy for post-conflict reconstruction,[75] while others are still defining their role. Lessons for post-conflict rehabilitation are outlined in Box 1,[76] and include the development of a post-conflict policy framework, the need for long term engagement, and a clarity of leadership, among others.

There is a substantial literature on rehabilitation of the health sector in post-conflict countries.[77 78 79 80 81 82] Case studies include Nicaragua,[83] Uganda,[84] Ethiopia,[85] Cambodia,[86] Kosovo,[87 88 89] Mozambique,[90 91 92], Afghanistan,[93 94] Angola,[95] Chad,[96] Palestine,[97] Former Yugoslav Republic of Macedonia,[98] East Timor[99] and Angola, Liberia and Cambodia.[100] Based on the literature, the main challenges and lessons learned regarding the rehabilitation of health systems in post-conflict countries are outlined in Annex 1. One of the most important findings is that in post-conflict countries, it is important to devise a national health policy framework at the beginning of the post-conflict process.

The end of the initial post-conflict phase has been described as the normalisation of relations with the World Bank and International Monetary Fund.[101] Some countries, however, are referred to as being "post-conflict" for many years after the end of the war, and the World Bank is increasingly engaging in early post-conflict reconstruction.[102]

Box 1: Lessons for post-conflict rehabilitation have been distilled in a recent report by the Development Assistance Committee of the OECD. It outlines nine key lessons for post-conflict rehabilitation from more than 50 formal evaluations of post-conflict initiatives.

1. Develop a coherent policy framework that recognizes "humanitarian space"
2. Commit to long-term and inclusive international engagement to support the peace-building process
3. Approach and manage the situation as a regional crisis – there is a need to coordinate approaches inside the affected country with approaches in neighboring states through a regional political framework
4. Clarify structure, leadership and do not "fly national flag"
5. Military forces should provide security rather than aid
6. Delegate authority, flexibility and strengthened monitoring regarding: a shared vision between donors and key local actors, joint needs assessment, early support for the rule of law and land tenure institutions, delegation of spending authority to the field, and no tying of funds; tracking systems for aid flows; clear hand-over from relief to development authorities; debt relief and underwriting of recurrent costs for civil administration.
7. Strengthen, use and support local institutional capacity
8. Understand and control the 'war economy'
9. Strengthen accountability and learning mechanisms of the aid system

THE HEALTH POLICY PROCESS

DEFINITIONS OF THE HEALTH POLICY PROCESS

Health policy is one component of a public health system. Other components include resources, organisational structure, service delivery and management, and support systems.[103] Broadly defined,

> "health policy embraces courses of action that affect the set of institutions, organisations, services and funding arrangements of the health care system. It goes beyond health services, however, and includes actions or intended actions by public, private and voluntary organisations that have an impact on health."[104]

Health policy analysts divide health policy into four component parts - content, process, context and actors – each of which can be analysed in various ways.[105] Policy *content* can be described as

> "both *technical* policies, for example on malaria, AIDS, health promotion, and *institutional policies*, for example, regarding financing, the private sector, organisation and management of service delivery. Part of the debate on priorities in health policy research revolves around the relative balance between technical and institutional concerns."[106]

Policy content has been described as operating at four main levels:[107]

- Systemic – where basic objectives and principles are decided (i.e. the basic structure of the health system).
- Programmatic – where priorities are set for interventions and are translated into

operational guidelines for service delivery (priorities are often based on burden of disease, cost-effectiveness, and political and societal values including equity and human rights)[108]

- Organisational - concerned with the structure of institutions responsible for policy implementation
- Instrumental - concerned with generating information to enhance the functioning of the health system.

The policy *process* is the setting of the policy agenda, through to policy design and implementation.[109] There are many different models that policy analysts use to examine the policy process[110] – four that are commonly used are described below. The first is a prescriptive model (the 'rational' model) that assumes that the process of policy formulation is rational and based on correct information. However, in reality, it has been found that this is often not the case. For example, in Uganda,

> "'... for years, policy was established by decree, no one knew what health policy really was; over the years it had become an *ad hoc* collection of declarations rather than an integrated legal framework for government action.'"[111]

Some analysts propose that the policy process is more incremental, whereby policy-making consists of slow bargaining between different interest groups to select priorities (incrementalist model). Others argue that policy-makers undertake a "broad review of the policy field without engaging in the detailed exploration of options as suggested by the rational model" (mixed scanning model).[112] Finally, there is the 'punctuated equilibria' model, which has recently been applied to priority setting in the international health policy arena. It argues that priorities are set via a "complex pattern of periods of stability, punctuated by bursts of attention" that are stimulated by new evidence and perceived need for health care.[113] Each of these models attempts to separate the policy process into its component parts to facilitate analysis; in reality, the policy process is likely to have characteristics of all these models.

A large variety of *contextual* factors - political, financial, social and cultural – impact on the formulation process.[114] One author has grouped these into four key influences on policy choice in less developed countries: quality of technical analysis; amount of political stability and support; capacity, motivation and support of the bureaucracy; and the influence of international actors.[115] There are many other models that categorize contextual factors in different ways; the discourse tends to centre on the role of the state, the nature of culture and civil society, and the balance between state and society.[116]

Finally, policy analysts consider the role of *actors* and their power relationships, as policy-making often depends more on political compromise than on rational debate (stakeholder or political mapping can be useful in detailing these power structures, and helps illuminate actors' agendas).[117] The concept of public policy implies the presence of strong state with the authority and the legitimacy to represent the interests of a population, and with the technical and administrative competence to finance, implement and regulate that policy.[118] It also implies the presence of a strong civil society which can engage with the state. However, policy-making can occur in states that have weak governance, such as in post-conflict and complex political emergencies, and stimulation of the policy process can facilitate the building of stronger state structures.

In conflict and post-conflict transition, civil society is impaired, and the state's authority and legitimacy may be contested

by national and international actors. The latter often presents an intractable problem for international actors because they do not wish to support non-legitimate regimes.[119] During periods of post-conflict transition, the question of legitimacy often arises when a new government has gained power through non-democratic processes and/or a transitional government is put in place until elections can be held. For example, in Cambodia, the majority of development aid was channelled through the NGO system instead of the transitional government, the pretext being limited government capacity.[120] However research showed that in reality, donor countries were hesitant to engage with the transitional government, preferring to wait until the election two years later. This resulted in a fragmentation of services and a weakening of government capacity and human resources, and undermined attempts to promote 'rational' allocation of resources to create a sustainable health system.[121]

In summary, health policy analysts focus on the actors involved in the policy process, the context in which they work, the processes used to create, change and implement policy, and the context within which policy is developed. By thinking through the policy implications for different actors, understanding the influence of group interests and values on policy choice and implementation, and determining whether the capacity and conditions exist for successfully implementing a policy, it is possible to alter the policy process and facilitate a policy's acceptance.[122]

THE DISRUPTION OF THE HEALTH POLICY PROCESS

Case studies that have explicitly examined the health policy process in post-conflict countries include: Uganda,[123] Cambodia,[124] Kosovo,[125] Mozambique[126] and Afghanistan.[127] Much less has been documented on the policy process in countries in conflict. Case studies include Mozambique,[128] Nicaragua,[129] and Angola.[130] Together, these experiences have shown that during a complex political emergency and in the post-conflict transition, the policy process is disrupted and fragmented at all levels, especially at the systemic level.[131]

Uganda provides an explicit description of the impact of war on the health policy process, and the factors that subsequently influenced it. The war, which had been ongoing since the 1970's, ended when Yoweri Museveni and the National Resistance Movement gained power in 1986. The main impact of the war on health policy formulation was a breakdown of the policy institutions, resulting in a policy vacuum at the systemic level, particularly with regards to primary health care and health care financing. The lack of a strong national health policy resulted in a proliferation of vertical projects run through systems parallel to the government, an emphasis on infrastructure, and fragmented service provision by non-governmental organisations. This approach undermined the capacity of the government, and resulted in significant inefficiencies in health service delivery.[132]

When the Ugandan situation was analysed in terms of the four factors influencing policy choice-- technical analysis, political stability and support, bureaucratic motivation, and international leverage -- it was found that all four factors played a large part in determining health policy. Technical analysis was weak due to limited data, failure to calculate recurrent costs, the time pressures of short funding cycles, and limited analysis of political and social constraints. Also, the problems in the health system were deemed to be infra-structural rather than structural, an underlying and probably incorrect

perception that greatly influenced subsequent policy content and process.

In terms of political stability and support, the Ugandan government saw health as a low priority. Vested interests supported physical rehabilitation and selective primary health care, and this, combined with public support for restoration of the old health system because it signified a return to normalcy, tended to promote health policies that favoured infrastructure development and vertical programs. Third, the bureaucracy had a limited ability to define policy options at a systemic level, and lacked interest in previous policy reviews, partly due to low pay and morale. Finally, international donors were poorly co-ordinated, had a preference for vertical programs and capital costs, tended to program in terms of expertise, not needs, and disconnected rehabilitation from longer-term development.

In conclusion, all of the above four factors influenced the formulation and implementation of systemic and programmatic policy, and resulted in a health care system that was not as appropriate and cost-effective as it could have been. These four factors have influenced policy-formulation in other post-conflict countries, and it is illuminating to analyse these factors when engaged in the policy process, or preparing to support or create policy formulation mechanisms.

REBUILDING THE HEALTH POLICY PROCESS

There are various ways to improve and/or rebuild the health policy process. One means that has been proposed is to ensure that recent initiatives to strengthen aid co-ordination mechanisms include measures to strengthen the health policy process. In developing and post-conflict countries, the aid coordination mechanisms under review include sector-wide approaches (SWAps) and performance-based partnership agreements (PPAs). In complex political emergencies, attention has focused on the Consolidated Appeal Process (CAP) and its Common Humanitarian Action Plan (CHAP). All of these aid co-ordination mechanisms include a policy formulation stage, however the exact means to create coherent, systemic, (government-based) health policy using these mechanisms have not been fully developed.

Some countries, such as Mozambique, Kosovo, the Democratic Republic of Congo and Somalia, have created country-specific co-ordination mechanisms that focus directly on health policy formulation. The effectiveness of these mechanisms has varied, and there is need for further research and documentation of these processes.

The following sections are arranged as follows. First, reasons to improve aid co-ordination mechanisms and initiatives to improve three major aid co-ordination mechanisms (Swaps, PPAs and CAPs) and their importance to health policy formulation are described. Then, country-specific initiatives that have focused directly on health policy formulation are examined in post-conflict countries (Kosovo and Afghanistan) and complex political emergencies (DRC and Somalia). Finally, the limitations of aid-coordination mechanisms, and their ability to stimulate health policy formulation processes are outlined.

Why Improve Aid Coordination Mechanisms

There have been recent calls by the humanitarian community to improve provision of basic needs to people affected by conflict, and to maximise the effects of humanitarian aid.[133] In response, studies are currently being done on how to improve aid co-ordination, needs

assessments, humanitarian resource mobilisation and allocation, and donor behaviour.[134] This section will focus on initiatives to improve aid co-ordination mechanisms between donors, UN agencies, NGOs and national governments as these initiatives have a direct effect on the creation of health policy formulation mechanisms.

There is a large amount of peer-reviewed literature on aid co-ordination in developing countries.[135] [136] [137] [138] [139] Documentation of aid coordination in complex political emergencies and post-conflict countries includes case studies on Angola,[140] Afghanistan,[141] the Great Lakes region and Rwanda,[142] Cambodia[143], Uganda,[144] Mozambique,[145] and more general reviews.[146]

Improved aid co-ordination mechanisms are seen to be important for the following reasons. First, "evidence is mounting that without effective co-ordination arrangements, donors may weaken rather than improve fragile health systems, undermining attempts to reform those systems."[147] There are increasing calls for responsible donor behaviour and greater aid coordination given that the policy process is increasingly being shifted to the international arena, and donors have an influence on policy formulation.[148] [149] [150] [151]

> "The weakness of public policy in these [developing] countries, together with the current preference of official aid organisations for policy-based lending,… means that the locus of health policy-making is increasingly internationalised – with decisions regarding major elements of the content of health policy in recipient countries frequently being made in Washington, Copenhagen, and London, rather than in national capitals."[152]

Recent results from the Global Commission on Macroeconomics and Health should help to focus attention on the need to support government and build capacity. It concluded that it is more cost-effective to strengthen the capacity of the government than it is to provide vertical programs.[153]

> "when spread across a number of interventions, the costs of the three major improvements needed [to the health system] – expanded physical infrastructure, improved training and performance of health workers and managers, and strengthened links between the health system and communities – will be smaller than the costs of trying to bypass the problems of limited capacity [through vertical programs]."[154]

This economic argument should stimulate donors to concentrate more on institutional capacity building in developing countries, as well as nascent post-conflict governments.(4) This may have implications for the health policy process because supported governments would increasingly be able to lead health policy formulation and implementation.

Finally, the geo-political landscape has changed dramatically since Sept 11, 2001. At the recent Monterrey Financing for Development Summit in April 2002, poverty and inequality were identified as one of the root causes of conflict, violence

(4) The Commission has also called for more research into supporting health system development in "highly constrained countries," which includes countries in conflict and post-conflict settings. Research would include how to set up health systems, prioritise health services and do this in a cost-effective manner given the fiscal constraints.

and terrorism. The Monterrey Consensus that emerged reinforced the idea that good governance, economic policies and legal structures would be rewarded with increased aid and trade initiatives. The implication of this Consensus for the humanitarian sector is that initiatives which support good governance and policy formulation are seen to be important as they may lead to increased funding.[155]

Types of Aid Co-ordination Mechanisms

Aid co-ordination mechanisms in developing countries include: donor co-ordination units within a Ministry of Health (MoH), geographical zoning, donor-only groups, a lead donor agency, regular collective MoH-donor consultations, general strategy/plans developed by MoH, earmarked budget support, pooling/ basketing of funds, common systems for resource management, sector investment programs and sector-wide approaches.[156] Some mechanisms are used more for consultation, policy harmonisation and the co-ordination of inputs. Others are more operational, and are used to manage inputs through agreed financing, accounting, or monitoring systems. Many of these instruments have not been that successful in developing countries– for example, few embrace all donors or a large proportion of aid, few are commanded by recipient authorities, and few have the authority to ensure participant compliance.[157]

Many of the above co-ordination mechanisms are used in post-conflict countries and complex political emergencies. Three major aid coordination mechanisms are discussed in more detail below: sector wide approaches (SWAps), performance-based partnership agreements (PPAs)[(5)] and the consolidated appeal process (CAP). All of these mechanisms require the development of health policy frameworks to guide allocation of resources, however the exact mechanism by which they do so needs to be further developed.

Sector-Wide Approaches (SWAps)

SWAps have been held up as the best possibility for aid co-ordination in developing countries because they avoid the problem of questionable legitimacy of donor decision-making, and aim to pass authority for policy formulation and programming to national governments.[158] They work on the basis of pooled funds,[(6)] which governments then use according to agreed upon policies and strategies. Thus SWAp mechanisms necessitate the development of collaborative, coherent health policy and strategies to guide the development of a health system and the provision of health services.[159]

Experience to date has been relatively positive in developing countries,[160] however it remains to be seen how successful SWAps will be in post-conflict countries. One obstacle for their use is that nascent governments have less robust policy processes and financial systems than more stable developing countries, which affects donor confidence in accountability. Despite this, East Timor has recently used a SWAp via a multi-donor trust fund. The result was positive as it "allowed for coherent sector development, ensuring the sustained financing of core activities and non-duplication of efforts."[161]

[(5)] PPAs are a contracting mechanism and not an aid coordination mechanism *per se*. However, they are classified as an aid coordination mechanism in this paper because they require, to a large extent, the creation of co-ordinated health policy by the Ministry of Health.

[(6)] Financing instruments include sector budget support, pooling agreements, basket arrangements and even tied aid.

There is little mention of using SWAps in complex political emergencies in the peer-reviewed humanitarian assistance literature, and the effectiveness of SWAps remains untested in the humanitarian context. One factor against their success is that there is no nationally representative, legitimate government body through which to channel humanitarian aid. Another factor that may hinder their success is the global trend to earmark humanitarian aid, [7] which leads to greater inflexibility in aid response and tighter controls on spending.[162]

Instead of SWAps *per se*, some donors have suggested other mechanisms to pool funds in complex political emergencies.[163] Such mechanisms could be modelled on UN common funding mechanisms.

> "Common funds are a more rapid and flexible mechanism to meet critical needs of vulnerable populations. An inter-agency consultative and participatory process to prioritise, allocate funds and evaluate impact and implementation is part of this arrangement. These funds, such as the Emergency Response Fund in Angola, the NGO Funding Mechanisms in DPR Korea and Indonesia, and Emergency Humanitarian Interventions in the DRC provide bridge-financing for NGOs and allow for quick impact projects in response to an upsurge in needs. These funds have been used to respond to sudden population displacements, disease outbreaks, and to prevent breaks in delivery of essential supplies."[164]

Common fund mechanisms do not necessarily result in the development of health policy frameworks however. One possibility for their further development may be to link common funds to policy-making mechanisms.

Performance-based Partnership Agreements

The World Bank and the Asian Development Bank, among others, are encouraging governments of developing countries to set policy and regulate services, but to refrain from actual service provision. Within the health sector, agencies other than the government will be expected to provide health services within a clearly defined policy framework set by a Ministry of Health.[165]

One mechanism that is used to define this new contractual relationship between the government and health service providers such as non-governmental organisations (NGOs), are Performance-based Partnership Agreements (PPAs). PPAs will enable NGOs and other non-governmental entities to submit bids to run health services in a specified geographic area, and deliver a basic service package according to specifications and indicators set by the government. They will be paid directly by donor agencies based on satisfactory progress, which is defined as

[7] From 1996-99, the total amount of un-earmarked (multilateral) aid grew by 32% compared to 1988-90. In the same period, earmarked (bi-lateral) aid grew by 150%, and the European Commission increased it by 475%. Some of this disparity is due to the fact that the Organisation for Economic Co-operation and Development (OECD) changed their reporting requirements in 1992, such that OECD members could include in their humanitarian assistance the costs for supporting refugees in their own country. However, the trend is also driven by: an increasing tendency to give funding directly to NGOs; a rise in the earmarking of funds to multilateral organisations (which allows donors to influence policy and increase their profile); and more calls for accountability. Finally, donors are sub-contracting work to "non-traditional providers" such as logistics companies, civil defence organisations, commercial security and other military and paramilitary organisations (Overseas Development Institute (ODI) April 2002. *International humanitarian action: a review of policy trends.* Briefing Paper. www.odi.org.uk).

actual performance as measured by an independent third party. The promotion of PPAs has been based, in part, on a successful pilot programme in Cambodia, where improved uptake of health services was linked with reduced costs for the poor, and an overall reduction in costs.[166] Most recently, the PPA system is currently being applied in the reconstruction of Afghanistan's health system.[167]

The implications of the PPA approach is that coherent health policy formulation is necessary to provide guidance to health service providers about issues such as selection of priority services, financing mechanisms and regions to be targeted. With the advent of PPAs, the health policy process will have to be strengthened and made more inclusive, ensuring that implementing agencies as well as government are part of the policy process.[168]

The Consolidated Appeal Process

An important aid coordination mechanism for humanitarian actors in complex political emergencies is the Consolidated Appeals Process (CAP). The main aim of the CAP is to consolidate and increase the coherence of the fundraising appeals by various humanitarian agencies working in complex political emergencies. Co-ordinated by the UN's Office for the Coordination of Humanitarian Affairs (OCHA), CAPs have raised over US $17 billion in contributions during 165 appeals over ten years. The primary importance of the CAP lies in the fact that it is the only co-ordination mechanism that brings together various UN agencies, Inter-Agency Standing Committee (IASC) members, NGOs and national governments to conduct shared analyses, define common goals and strategies, delineate sector objectives and lay out future activities for a humanitarian emergency. The CAP is also important in that it provides an effective mechanism for rapid mobilisation of funds for relief, and helps ensure that funding gaps are filled during the transition to post-conflict. However, there are numerous problems with the CAP as detailed in a recent external review:[169]

- *Weak coordination mechanisms* – While some co-ordination groups continue to function after the annual CAP has been submitted, some disband until the next CAP is required, thus hindering ongoing collaborative strategic planning and analysis. Also, not all stakeholders are fully involved – for example, NGOs participation ranges from attendance at workshops to being a full partner in the appeal process. Many NGOs do not take part at all, preferring to raise funds directly from donors.[170]

- *Weak needs assessments* – CAPs do not report on needs where agencies have been unable to secure access.[171] Also, needs assessments are not done in a uniform manner, which makes it difficult to allocate resources equitably between countries, as well as within a country.

- *Inappropriate resource allocation* - There are enormous discrepancies in allocations that cannot be explained solely by different costs or proven need. For instance, the Former Republic of Yugoslavia received US$166 per capita compared to Eritrea, which received US$2.[172] These types of discrepancies have been attributed to "what agencies think the market can bear rather than an objective indication of need,"[173] resulting in a gap between needs and response. Donors have also admitted that their funding decisions are not based directly on the CAP, and that

the CAP is unlikely to convince them to fund a project that they would not otherwise fund. This leads to frustration that there is little correlation between the quality of the CAP and funding received.[174]

- *Decreased resource mobilization* – The CAP remains the primary means for coordinated resource mobilization, however its share of total humanitarian aid funds has fallen from 40% to 30% over the last ten years,[175] despite an increase in humanitarian funding.[176] This has been attributed to competition from other NGOs for donor funds, and the fact that the appeals now include funding for transitional activities, which historically have not attracted much funding.[177] As of mid-year 2002, the 18 appeals, excluding Afghanistan, have only received a 29% response rate.[178]

- *Inadequate strategic planning* – Due to inadequate prioritisation and screening processes, projects often do not meet the objectives as set out in the CAP. Agencies sometimes design their projects prior to the setting of a strategic plan and objectives due to different project timelines and funding cycles. This undermines the CAP's strategic purpose, which is to identify, prioritise and raise funds for the most pressing needs.[179]

- *Inadequate monitoring systems* – Monitoring systems are weak, and are undermined by the lack of quality baseline data. This affects the quality of the needs assessments, and ongoing strategic planning. Without this information, the CAP's ability (and thus credibility) to produce evidence-based strategic plans is weakened.[180]

- *Insufficient use in advocacy* – The CAP should be used to point out the large discrepancies in funding, which undermines the humanitarian principles of neutrality and impartiality. Also, CAPs should be used to highlight issues of human rights abuses, access problems, and lack of respect for humanitarian principles.[181]

Due to the above weaknesses in the CAP system, numerous studies have recently been commissioned on how to improve the CAP, including a CAP review, a DFID study on improving financing and aid flows, and the IASC working group on the CAP.[182]

One focus of discussion is to separate the process of formulating the Common Humanitarian Action Plan (CHAP) from the appeals process, which is only open to members of the Interagency Steering Committee. This may encourage humanitarian actors who normally don't become involved in the CAP process to play an increased role in creating policy and strategy for the sector.[183]

The drive for reform of the CAP reflects the view that the CAP remains the best humanitarian aid co-ordination mechanism currently available to the UN agencies for joint planning, quick mobilisation of funds, and for provision of links between projects during transition phases.[184] However, agencies involved in reforming the CAP must be cognisant that the CAP cannot 'co-ordinate away' structural obstacles, such as different funding cycles, project timeframes, donor and agency mandates, and discordant foreign policy and politics.

Country-Specific Aid Co-ordination Mechanisms used to Create Health Policy

Post-Conflict Settings

The development of systemic and programmatic health policy through country-specific aid co-ordination mechanisms has been important in post-conflict countries, as indicated by experiences in S. Africa,[185] Palestine,[186] Mozambique,[187] Kosovo,[188] Afghanistan,[189] and Cambodia, Angola and Liberia.[190] In post-conflict South Africa, early discussions between the African National Congress and the progressive health movement facilitated later policy processes. In Palestine, a draft health policy[191] provided an important forum for debate between key actors and donors, although it was never adopted due to issues surrounding mandate, ownership and participation.[192]

In contrast, the experience of Mozambique highlights the importance of policy formulation created before the peace-accord was signed in 1992.

> " Frameworks for post-war reconstruction, completed before the peace agreement, stressed equity and affordability, thus attracting considerable donor support. The planning exercise kept central officials concentrated during a period of military stalemate, contributing to a relatively high morale within MoH and avoiding the loss of key cadres… In the frantic climate of the transitional period, the pressing demands of reconstruction sidelined planning activities. Thus, the plans finalised by 1992 were successfully implemented, whereas areas lacking a clear MoH policy were left open to many inconclusive donor-led proposals."[193]

The case study of Mozambique clearly demonstrates how health policy formulation during the transition to a post-conflict phase aided the nascent MoH in planning and implementing future health sector objectives and activities.

Kosovo provides the best example of the development of a health policy framework in a post-conflict setting. In Kosovo, a systemic, interim health policy document was developed and promulgated within three months of the end of the war in 1999.[194] It was drawn up by the WHO in consultation with some members of the Kosovar medical community, and promoted reform of the health system towards a more western European model. The document outlined policy goals and organisational principles of the reformed health system. It then detailed the structure of primary and secondary care, hospital services, public and environmental health, reproductive health policy, drug policy, and plans for the physically disabled. It also contained a health management plan, principles for human resources development, municipal and regional plans and budgets, and essential infrastructure and support. It concluded with a six-month action plan, as well as a medium-term health strategy. The policy document aimed to ensure sustainability of the health system by clearly stating that humanitarian resources would not be used to expand the health system beyond the limits of national revenue, and would only be used to repair damage sustained because of the war and years of neglect, and to fund problems that were created specifically by the emergency. It also allowed for inputs into orientation and training.

While Kosovo's interim policy was judged to be successful, there were some issues that arose as a result of the process used to

develop it.[195] Some questioned whether reform at such an early stage was feasible and appropriate because local capacity was limited, and service provision was a priority. Others felt that local ownership was lacking due to the restricted number of consultations. [(8)] This was overcome over time by strengthening the Ministry of Health, who gradually took control of the process, and ensured that ongoing consultations were made more inclusive.

Overall, it was concluded that while implementation of the health policy was not uniform or complete, the policy played an important role in co-ordinating significant amounts of external assistance into the development and reform of the health sector without jeopardising relief activities. The report concluded that WHO could promote the development of such health policy frameworks, but that this would require the WHO to "develop and maintain the capacity for rapid situational analysis and policy development and be willing and able to deploy that capacity rapidly."[196]

A recently conducted case study on the reconstruction of Afghanistan's health system examined the current health policy process in detail.[197] The author analysed four post-conflict case studies (Cambodia, Uganda, Mozambique and Kosovo) and based on these, compiled eight common lessons for post-conflict rehabilitation of the health sector (Annex 1). These were then compared against the reconstruction process in Afghanistan. The author's conclusions for the health policy process were as follows:

1. "Early and direct placement of strategic policy expertise in the ministry is critical to the effective organisation of both national and international reconstruction activity." Mechanisms should be created to ensure immediate dispatch of a policy team.

2. "Policy work should be separated into fast and slow tracks so that responses can take advantage of narrow and urgent 'windows of opportunity' while embarking on essential consultation and capacity building in other areas." To respond to immediate needs, some policy issues need to be fast-tracked and strategic guidance given to donors. There also needs to be a slow-track to deal with sustainability issues and future development of the health system.

3. "Co-ordination is barely a useful term anymore and needs to be 'unpacked' to its constituent parts if progress towards its multifarious goals (resource allocation, operational partnership, technical policy development, and information management) is to be achieved." Post-conflict actors must review co-ordination structures with particular attention to interface areas and feedback channels.

4. "Lack of attention to dissemination of information undermines efforts in co-ordination and communication." Therefore, it is important to establish mechanisms to both collect AND disseminate information.

5. NGOs need financial, moral and technical support to build capacity to respond to the demands of health reconstruction post conflict."[198]

[(8)] Members of the Albanian medical community had taken part in the consultations, however the Serbian medical community had refused to take part. Also, some stakeholders felt that the policy was made too quickly, while others concluded that it was not completed quickly enough.

All of these activities should take place as soon after 'peace' as possible – i.e. days and weeks, rather than months.

Specific and practical recommendations for supporting the health policy process in Afghanistan included: urgent placement of a long-term strategic policy team in the ministry; recruitment of facilitator/public health specialist to help improve capacity in the NGO community; establishment of a health sector newsletter; and clarification and strengthening of co-ordination mechanisms. The uptake of these recommendations is being spurred by the PPA program, which is currently being implemented in Afghanistan.

Complex Political Emergency Settings

Systemic policies, like the one developed in Kosovo are rarely made during complex political emergencies because governments and/or rebel groups do not have the authority and legitimacy to create and implement national policy. Programmatic policies are also rarely developed by humanitarian actors and government/rebel groups due to unclear lines of authority, limited policy leadership, a multitude of mandates and weak aid co-ordination mechanisms. For example, the CAP produces strategic objectives and plans that could be classified as programmatic policy, however, these documents have limited legitimacy due to the weaknesses in the CAP previously described. If the CAP, and more specifically the formulation of the CHAP, was greatly strengthened and made all-inclusive, it would have the potential to produce programmatic health policies that would provide useful guidance to the humanitarian community.

One example of programmatic health policy formulation in a chronic conflict recently occurred in the Democratic Republic of Congo (DRC). [199] The process focused on creating a strategic health document that would impact on the enormous morbidity and mortality endured by the Congolese. Historically, the DRC had a surprisingly robust primary health care system despite years of neglect and huge movements of internally displaced across the region. [200] However, the latest round of the war has left the health system in the Eastern DRC in almost total collapse, [201] with an excess mortality of approximately 2.5 million people over 32 months (from August 1998-April 2001). [202] To address the catastrophic health situation in the DRC, and to find ways to reduce the extraordinary level of mortality, UNICEF and WHO facilitated a meeting in Nairobi in September 2001. It brought together health officials from rebel-controlled areas and the Kinshasa government for the first time in a decade, as well as various donors and NGOs working in government and rebel-controlled areas. A minimum package of services was devised that focused on simple methods to address the top seven causes of morbidity and mortality in the DRC, as well as a basic surveillance system. The results of this co-ordination effort are still to be determined, but discussions are ongoing regarding financing and management options, and methods for further co-ordination. [203] However, recent evidence suggests that the process has stalled due to uncertain commitment by the UN agencies, and difficulties in harmonizing the process with ongoing health policy formulation in Kinshasa, among other factors. [(9)]

Compared to the DRC, Somalia is more advanced in terms of developing an inclusive health policy that guides both donors and the humanitarian community. The Somali Aid Coordination Body (SACB) was started in 1995 and grew into

[(9)] The Conflict and Health Program at the London School of Hygiene and Tropical Medicine is currently conducting a study in the Eastern DRC to determine the extent to which this policy was taken up.

a Nairobi-based, institutionalised body funded by different donors.[204] The EC Somalia Unit financed the position of a Health Sector Co-ordinator and a Health Co-ordination office.

The precursor to the SACB was formed in March 1995, when four international NGOs met in Mogadishu to form a cholera task force. By May 1995, Unicef concluded that co-ordination was important, and UNICEF and WHO asked the nascent "Mogadishu Health Co-ordination group" which was later renamed the SACB, to host all organisations active in the health sector in Somalia. Different working groups were established in order to provide technical assistance. However, as there was no basic health policy in place in Somalia that provided a framework to integrate the outcomes of the different groups, the different working groups had trouble harmonising their results.

Thus, the working groups focused on the development of a Minimum Package of Health Services for every region. They also moved some of the process to Somalia in order to facilitate the participation of Somali and expatriate technical staff, and to ensure that the SACB was working towards priorities that were based on local needs and capabilities. The various task forces and working groups created guidelines, standards, policies and procedures to guide agencies and other service providers working in Somalia. A consensus building process was used between the international actors and the SACB in order to minimise any negative impact of interventions, and to avoid overlaps and duplication. The major donors (EC and USAID) agreed to include these standards as part of their contracts with the implementing organisations, and the hope is that all donors funding interventions in the health sector will adhere to the enforcement of the standards.[205]

To summarise, experiences in Mozambique, Kosovo, Afghanistan, DRC and Somalia show that there are many ways of creating health policy formulation processes. Aid co-ordination mechanisms are useful in that they standardise practice between countries, and thus lessons are easily transferable. However, country-specific processes are also important because they focus specifically on building the policy process, and do so in a contextually specific manner. Both types of mechanisms can be used in synchronization – for example, a SWAp could be conducted in co-ordination with a country-specific policy formulation mechanism, which would bring together the strengths of both mechanisms.

The Limitations of Aid Co-ordination

Improved aid co-ordination can only go so far to improving humanitarian effectiveness due to several systemic and political problems. In order to analyse the effectiveness of aid co-ordination in promoting the health policy formulation process, it is instructive to examine some of the limitations of aid co-ordination.

The first limit to aid coordination in complex political emergencies is that aid co-ordination is made much more difficult by the lack of a neutral political interlocutor. For example, despite Operation Lifeline Sudan's success in coordinating a humanitarian response with both government and rebel groups, there still remained major hurdles for aid coordination between all the actors. As a result of this, service provision remains fragmented in terms of geography and mode of service delivery.[206]

Secondly, it has been argued that a lack of political coherence is more problematic than a lack of aid coordination. For example, in a February 1998 symposium on the relationship between humanitarian

action and political military action organized by the Belgian Ministry of Foreign Affairs, one working group identified the

> "absence of coherence among political institutions – donor governments, UN member states, Security Council members, international and regional intergovernmental bodies and the UN's political department – as a more serious constraint on consistent and effective humanitarian action than problems among aid agencies themselves." [207]

Others argue that humanitarian aid should not be coherent with politics as it constrains humanitarian action.[208] The study of the Strategic Framework for Afghanistan (SFA)[209] highlights some of these issues. The SFA was part of the 'new humanitarianism'[210] movement in the 1990s that promoted greater coherence between aid and politics in an effort to encourage more politically informed and principled management of humanitarian resources, and the strategic application of humanitarian assistance to conflict reduction.[211] However, the SFA failed to enhance policy coherence because of the different political views held by the UN Special Mission to Afghanistan (UNSMA), other UN agencies, and international organisations. UNSMA saw the Taliban as more of a "rogue" than a "failed" state, and so promoted the politics of isolationism, and greatly restricted development aid. The remainder of the international community was divided on this issue of isolationism versus engagement, which was ultimately deemed detrimental to health service provision.[212] The linking of humanitarian aid to political imperatives was seen to threaten humanitarian actors' neutrality and impartiality, and may have compromised access.[213] Some argued that more aggressive political and diplomatic mechanisms should have been used to engage the Taliban government, instead of relying on the humanitarian sector to provide political pressure. The study concluded that lack of political coherence was something that could not "just be co-ordinated away" and that further discussion around these issues was warranted.[214]

Finally, organisations have difficulty in applying the lessons of aid-co-ordination.[215] The case of Rwanda provides a telling example whereby some mechanisms of the humanitarian apparatus were adjusted as a result of the many studies conducted, but the more systematic problems still remain.

> "Reforms to date have been largely technical, procedural, logistical and administrative in nature. … Still to be addressed are the weak structures of humanitarian co-ordination and the knotty political and humanitarian tensions underlying the intergovernmental system itself."[216]

There are many reasons for this inertia, many of which can be linked to constraints in the institutional cultures of humanitarian organisations: the tendency to approach every crisis as unique; the action-oriented ethos of humanitarian actors; defensiveness to criticism and a lack of accountability built into the system. In order to address the constraint of institutional culture, some have argued that implementation of quality management models that institutionalize learning, as well as self-regulation rather than accreditation by donors are the way forward.[217] Lack of accountability is seen as the most difficult to address as no single institution is held accountable for international humanitarian interventions, and there are no clear lines of authority,

reflective of co-ordination by consensus or default.[218]

To summarise, there have been many developments in health policy formulation in complex political emergencies and post-conflict countries. Health policy formulation processes can be supported through various formal aid-co-ordination mechanisms, and through country-specific co-ordination mechanisms that have been developed explicitly to promote health policy processes. There is a need to improve these mechanisms, and to further explore their role in supporting the policy formulation process. Finally, the limitations of aid-co-ordination mechanisms need to be recognised when analysing the role of aid co-ordination in supporting policy formulation. The next section details the need for more comprehensive research on the health policy process and its evidence-base in order to address some of the above issues.

THE NEED FOR A RESEARCH AGENDA

There is a need for more research on the health policy process in complex political emergencies and post-conflict countries. This is especially acute for complex political emergencies as there is not enough documented evidence to create a list of 'lessons learned.' More research on the technical aspects of health interventions in complex political emergencies is also required. The current lack of data hampers health policy formulation as policy-makers do not have enough high-quality information to make informed decisions.

RESEARCH ON HEALTH POLICY PROCESSES

More research needs to be done on the health policy process and the creation of health policy frameworks in post-conflict and complex political emergency settings. In particular, there is very little in documentation and analysis of experiences in complex political emergencies, thus there is little experience to draw upon.

There is a growing descriptive literature on the subject as more and more actors start to document their experiences, and these documents increasingly find their way into the public domain via the internet. However, many of these documents remain difficult to find, and very few of them are peer-reviewed for an assessment of methodology, rigour and validity.

The documents written so far constitute a body of evidence regarding "lessons learned" with regards to the health policy process. What is needed now is to apply these lessons, and use operational, "real-time" research and evaluation techniques to refine and document further initiatives, and actively stimulate discussion amongst health policy actors.

For example, in the recent Afghanistan case study, recommendations were made for further research on specific tools and mechanisms that would facilitate organisations to take part in the policy process and/or provide support.[219] These need to be taken up by humanitarian actors for the purposes of operational research. Recommendations included 'unpacking' co-ordination and creating practical implementation 'checklists' that could be used by policy-makers. Such checklists would clearly differentiate co-ordination into its different components (for example consultation, information sharing, resource coordination, information management), and would offer guidelines on mechanisms to address each.[220] Another recommendation was to create a series of step-by step manuals on reconstructing key

areas of policy in post conflict settings. Such manuals would be useful for policy-makers who are often inexperienced in post-conflict rebuilding, and would facilitate transfer of knowledge from one post-conflict setting to another. The manuals would include "a set of evidence and experience-based guidelines for key areas of policy development eg: human resources (which would for example outline options for use of incentives, ways to reaccredit, compulsory post-graduate service…), financing systems, decentralisation models and so on – with information drawn from post conflict settings…"[221]

The final recommendation was to develop a policy 'critical path,' which orders policy decisions so that blockages to further progress are foreseen and addressed (see box below). 'Fast-track policies' could be put in place to deal with immediate needs of the population and control the initial, rather chaotic process of rehabilitation by setting some ground-rules. At the same time, 'slow-track' policies could be developed to address issues of health system reform, rebuilding, and sustainability. As experience in Afghanistan showed, "clearly separating different needs and objectives for health policy in Afghanistan might have allowed for clearer, more targeted guidance to donors and implementing partners, thereby increasing the effectiveness of the advice as a co-ordination tool."[222]

Such a policy tracking tool would give needed guidance to policy-makers who may be new to the policy process.

In complex political emergencies, initiatives to support the health policy process, and documentation of these initiatives are much weaker. There is need for more research and documentation of current health policy processes (for example in the DRC, Somalia and South Sudan), and an analysis of the potential role of health policy in complex emergencies. This information should be disseminated into the public domain, and used to provoke discussion amongst humanitarian actors about the role of health policy in complex emergencies, how the policy process can be stimulated and supported, and the pitfalls and opportunities of policy making in these volatile, fast-moving situations.

Starting to develop a policy 'critical path'...

AFTER THE PEACE ACCORD

After:	***Fast Stream***	***Slow Stream***
2wks	Joint assessment missions	
4wks	I year strategic guideline for donors (endorsed by MoU?) Provisional relationship between MoPH and service providers	1.Type of health service? (all state, state-private mix…) Review of ministry structure
8wks	Infrastructure review and facility definition Registration and category definiton of human resources	Options for health financing *2.*Mechanisms to test workforce competencies
12 wks	Interim supply and logistics policies Definition of interim service goals and mechanisms for implementation	Training and curriculum redesign 3. Normative basic health service package design
etc		

Please note this model is only intended to illustrate the idea of a process towards a critical path: the steps are not in any way considered correct, nor does the diagram conform to the requirements of a critical path. Extensive work would be needed to align and order the different components to discover which can be explored in parallel, which need to be priority and how much time might be allocated to each process. (*Extracted from Bower 2002, Ibid*)

CREATING A BETTER EVIDENCE-BASE IN COMPLEX POLITICAL EMERGENCIES

There have been recent calls for research into the provision of health care in complex political emergencies because of important questions about the quality of health services and impact on populations,

[223] as illustrated by questionable interventions in Rwanda,[224] South Sudan[225] and Ethiopia[226] that may have contributed to morbidity and mortality. One recent document points out: 1) millions of dollars are spent on health care for refugees and IDPs every year; 2) these populations are unstable, and thus health actors are constantly challenged to change their models of health provision; 3) agencies face the challenge of providing health care and capacity building in the hopes of a future post-conflict transition; 4) there are almost no evaluations of the effects of multiple health programs in a particular region, with the exception of the interagency Rwandese studies; and 5) some agencies are more developed in monitoring and evaluation than others and many are limited in terms of their capacity to measure the outcomes of their programs.[227]

A recently completed research agenda outlines three main areas for research in complex political emergencies[228]: 1) impact of conflict on heath status/burden of disease; 2) response of communities, care providers, health services and health systems to conflict; and 3) the rationale, features and effects of internal and external interventions. Questions particular to each of these points are summarised in Annex 2. Another, more technical public health research agenda outlines questions specific to nutrition, reproductive and women's health, communicable diseases, health services management, information management, mental health and ethics.[229] These agendas reflect the argument that international relief agencies

> "should base their health intervention on objective epidemiological data, especially standardized rates of morbidity and mortality. Most deaths during complex humanitarian emergencies are due to preventable causes, especially increased rates of infectious diseases malnutrition and violent trauma. The most appropriate health interventions are therefore based on the models of public health and primary health care, emphasizing disease preventions and health promotion."[230]

Despite this, research on complex political emergencies remains severely limited. One argument against research on public health interventions is that "many approaches from evidence-based public health, such as the provision of food, potable water, and shelter are regularly applied during interventions."[231] However, while there is epidemiological evidence that certain interventions from developing countries work in controlled, refugee-type settings, there is a lack of evidence for interventions for dispersed populations in terms of epidemiological data on communicable diseases, how to adapt basic health care interventions, and whether such adaptations have proved effective. [232] Such studies are important given the enormous impacts of conflict on populations and health systems (for example extremely eroded assets, targeting of medical staff and infrastructure, and limited access due to insecurity) which make replication of effective interventions much more difficult.

There are numerous difficulties in conducting technical research in complex political emergencies. One problem is attribution of impact to health interventions.

> "Many determinants of effectiveness that are part of the physical and organisational setting of humanitarian medical aid (for instance, political decisions, military action, and natural disasters) are extremely variable and unpredictable. Not only are

> they therefore hard to measure and to document thoroughly, but they also render problematic extrapolations from one context to another, since settings of interventions vary greatly. The sheer number of determinants of effectiveness (which often change rapidly) also makes causal inferences tenuous. As a result, accurate quantitative estimates of effectiveness and efficiency are often either not possible in humanitarian medical work, or limited in important ways."[233]

Other reasons often cited are problems of insecurity and logistics which limit primary data collection (although there are a number of independent researchers who have found it possible to do rigorous research in these settings).[234] In addition, many agencies and international organisations, the UN included, lack the necessary evaluation and research skills. Finally, operational funding takes priority -- the tendency is for humanitarian agencies to act first and rarely investigate the effectiveness of their actions.

Due to the above constraints, very limited funding has been allocated to pure or operational research in complex political emergencies. However, many still believe that it is important to conduct more research on humanitarian health interventions in order to improve the effectiveness of humanitarian aid. The recent introduction of industry standards as laid out in the Sphere Guidelines[235] and the Humanitarian Accountability Project may stimulate such research as donors are starting to use the standards to assess performance. This is seen to be both positive as standards make actors more accountable, as well as negative because the standards have a weak evidence-base (especially when working with dispersed populations), and the context of the situation may not allow agencies to meet the standards.[236] Given these recent developments towards accountability and standards, it is in the humanitarian sector's interests to improve the evidence-base upon which these standards are based, and to further contextualize the use of standards. Logical frameworks and performance evaluations can be used to guide such operational research.

Other authors maintain that health interventions serve a multitude of roles, including protection, and that due to the difficulties in evaluating the epidemiological effectiveness of public health interventions, effort should be directed instead towards documenting the "inequities and violations of human rights, as well as testifying to the resulting suffering."[237] Frameworks for the evaluation of protection have been created to this end.[238] More discourse around this issue would highlight the various reasons s that health agencies engage in conflict, and how these varying mandates influence the research agenda.

It is important to acknowledge that evidence is only one of the factors which influences policy-makers, in that policy-makers are driven by other rationale, such as political imperatives and civic demands.[239] However, the evidence-base regarding the effectiveness of public health interventions in dispersed complex emergency settings is particularly weak compared to other situations, and this, combined with the imperative to improve the effectiveness of humanitarian aid, should drive the research agenda forward.

DISCUSSION AND CONCLUSIONS

Health policy frameworks have been important in the rebuilding and reform of health systems in post-conflict countries, such as Mozambique and Kosovo, and are being explored in current post-conflict situations, such as Afghanistan. The advantages of health policy frameworks in post-conflict settings is that they provide a clear vision of how the health system should be rebuilt and reformed, and lead to detailed policy objectives and operational strategies. They enable the effective channelling of large amounts of external assistance into the development of the health sector, and so maximise the impact of humanitarian aid on vulnerable populations. Once a country has moved into the post-conflict phase, health policy frameworks not only aim to decrease morbidity and mortality, but also focus on building the sustainability of the health system.

In complex emergencies, the effectiveness of health policy frameworks remains untested, although based on experiences in post-conflict countries, and complex political emergencies such as Somalia, such frameworks are likely prove useful to humanitarian agencies, which currently deliver services in a fragmented manner using different strategies and health care models. Such frameworks could provide policy guidance, and promote a co-ordinated approach, thus maximising the effect of humanitarian aid. However, there are many constraints to the creation of such health policy frameworks in complex political emergencies, such as the questionable legitimacy and authority of the remaining government, harmonization of humanitarian aid policy with existing government policy, and lack of authority of humanitarian agencies over each other, amongst others. The nature of this policy milieu makes it more difficult to create policy frameworks, and the role of health policy frameworks in such settings needs to be explored further.

THE POTENTIAL OF AID CO-ORDINATION MECHANISMS

Aid co-ordination mechanisms have been the major mechanisms used to create health policy frameworks. SWAps, PPAs, CAPs and country-specific mechanisms such as in Somalia and the DRC all have the potential to support policy-making processes, and indeed most require that coherent policies are put in place. All of these mechanisms need to be further developed, however, with a focus on the creation of functioning, transparent health policy processes. Current review processes should also address some of the structural obstacles to aid co-ordination, such as the trend to earmark aid, discordant mandates and the politicisation of aid.

The nature of aid co-ordination can impact on the creation of policy frameworks. For instance, the 1994 DHA (OCHA) study of the Rwandan refugee crisis categorised aid co-ordination into three types[240] – co-ordination by command, consensus and default. It concluded that co-ordination in complex political emergencies is generally by consensus or default, and that a more assertive model of co-ordination (i.e. command) is necessary for activities to be effective.[241] A move towards more of a command structure may have positive implications for the health policy process as some argue that co-ordination by default works against the creation of policy frameworks presumably because there is lack of clear policy leadership and accountability.[242] However, the recommendation to move towards more of a command structure has never been acted on mainly because humanitarian agencies have limited authority and legitimacy over each other, the populations they work

with, and warring or nascent governments.[243] The maintenance of organisational independence is also a factor. Thus the discourse continues regarding whether co-ordination by command is required and feasible, and which UN agency, NGO, or other international organisation has the capacity and legitimacy to take over this role.

As an example, it has been suggested that the WHO should take a more active role in facilitating aid co-ordination mechanisms and setting national health policy frameworks,[244] which is a shift from its usual role.[245] [246] This policy role has been incorporated into WHO's Core Commitments in Emergencies as follows: (10)

> "Defining an integrated health policy for preparedness, emergency response and post-conflict, for a coherent health sector development resilient to emergencies, to link relief efforts with national capacities and initiate future health system reform." [247]

A policy role is most feasible in post-conflict settings where there is a legitimate interlocutor to engage with, as happened in Kosovo, however the WHO may also take a lead role in health policy formulation in conflict settings as illustrated by the DRC initiative.

In order to succeed, the WHO will need to greatly strengthen its leadership capabilities in the policy process.(11) Suggestions for improvement include focusing on the policy process not implementation, developing skills and capacities in health policy analysis, lowering staff turnover and procuring funding from many different sources so as to be perceived as a neutral interlocutor. WHO also needs to develop its flexibility and quickness of response in terms of staffing, procurement and funding when faced with a post-conflict transition or a complex political emergency.[248] [249]

There are indications that the WHO may be making some of these improvements according to recent reports on their plan for Iraq in case of regime change. "…A humanitarian relief operation has been designed to meet the needs of conflict. Proposals to recreate and construct afresh health services are also well advanced."[250]

The above initiatives should help build WHO's capacity, and therefore its credibility. The problem of legitimacy(12) remains however, as WHO, like all UN organisations, has no power or authority over other UN agencies or international organisations and governments, except that which it wields in terms of technical expertise.

THE IMPORTANCE OF CONTEXT IN POLICY CHOICE

When analysing the health policy process, it is useful to analyse the four factors influencing policy choice – "technical analysis, political stability and support, bureaucratic motivation, and international leverage," all of which are impaired in

(10) Other WHO documents may need to be harmonised with this commitment. For example: WHO: Providing services and fulfilling responsibilities, 30 April 2001; WHO: Disaster preparedness and response March 2001. And WHO in disaster reduction and humanitarian action mission brief Sept 2000.

(11) For example, in the DRC, while it was able to initiate a policy process, it was not able to carry it forward due to indeterminate commitment and staffing problems (WHO official, pers comm.).

(12) Legitimacy can be defined as authority by legitimacy – where the powerful actor holds an acknowledged right to command. Authority can also be obtained through inducement (using positive or negative sanctions), competence (through expertise), and personal authority (or willingness to please) (Walt, Pavignani, Gilson and Buse 1999 Ibid).

complex political emergencies and post-conflict countries due to damage sustained to state structures and civil society.

More technical analysis of health interventions in complex political emergencies and post-conflict countries would provide a useful, and much needed evidence-base for policy makers. Political stability is often weak, and political support needs to be gained through engagement of political actors into the policy process. Bureaucrats in all organisations – international and government – also need to be included in the policy process in order to obtain their commitment to reform, and their input into it. As one author states,

> "there is much to be said for ensuring all actors are kept up to speed with the process of policy development – the debates, the alternatives, the progress of discussions – not just decisions, not only to reduce the risk of misunderstandings circulating and influencing action, but also because the *fait accompli* approach closes off opportunity to garner expertise and experience."[251]

Finally, issues around international leverage and policy coherence need to be highlighted and addressed by the donors and the wider humanitarian community in order to continue to learn from previous experience -- such as the Afghanistan Strategic Framework -- about the benefits and drawbacks of policy coherence, and the importance of other mechanisms besides humanitarian aid that can, and should be used to prevent and resolve conflict.

A FOCUS ON HEALTH POLICY PROCESSES

More focus and support should be given to the health policy process, and the formulation of coherent policy. Commitment should be given by both donors and implementers to being part of the policy process via committed staff and resources. To have strength of persuasion, it is particularly necessary that donor agencies are fully involved in the policy process to link prioritization to resource allocation. The policy process -- organised via aid co-ordination mechanisms and/or country-specific policy mechanisms -- functions better when it is transparent, accountable and inclusive. Based on previous experience, it is helpful if lead policy actors have a strong mandate from other humanitarian actors. Authority to make decisions and allocate resources are important when co-ordinating and setting health policy with a view to making it operational.

Humanitarian agencies should further develop their policy analysis capabilities in order to better understand how context, process, actors and content impact on the policy arena. One recommendation is to hire designated health policy analysts to drive specific policy processes forward, and to co-ordinate and/or create mechanisms for policy formulation. In order to guide them, it would be useful to develop policy-formulation guidelines and checklists via operational research and reviews.

Finally, in post-conflict countries, it has been found useful to conceptualize the policy processes as having two tracks - a 'fast' policy track that controls the immediate rebuilding of the country and meet immediate needs, and a 'slow' policy track that is focused on rebuilding the health system and ensuring its sustainability. This concept could also be used by policy-makers in complex political emergencies, especially if there is a movement towards post-conflict transition, as occurred in Mozambique in 1992.

A CHANGING PARADIGM FOR HEALTH POLICY DEVELOPMENT?

In conclusion, there seems to be growing consensus in the literature that the creation and support of health policy processes in post-conflict and complex political emergencies is important, and that it leads to better health service provision. Recent studies on post-conflict policy initiatives are reassuring, as are the few documented experiences from complex political emergencies, that better health policy formulation leads to improved health outcomes in these settings. However, empirical research is lacking, and needs to be strengthened in order to support these claims.

As the geopolitical scenario changes to more of a security agenda, there will be an increasing focus on good governance, which includes policy formulation and implementation. At the same time, the work of the Global Commission on Macroeconomics and Health makes the argument that decreasing the burden of disease will facilitate the growth of poor economies. This, combined with the Monterrey Consensus that decreased poverty may lead to decreased conflict and violence, leads to multiple conceptual reasons to improve health policy processes – to improve governance and to improve health -- both of which may lead to economic prosperity and decreased conflict in the world.

As support to policy formulation is seen to be important both in terms of better health service provision and better governance, the humanitarian community should learn more about policy analysis, lend support to the policy process, and further investigate the effect of policy formulation in complex political emergencies and post-conflict countries.

ANNEX 1 –EIGHT COMMON LESSONS FOR POST-CONFLICT REHABILITATION OF THE HEALTH SECTOR

The following have been directly abstracted from Bower's work,[252] which are based on experiences from Kosovo[253] [254] [255] Uganda,[256] Cambodia,[257] Mozambique.[258] [259] [260] Experiences from Nicaragua,[261] Ethiopia,[262] Angola,[263] Chad,[264] Palestine[265] and Liberia further inform these lessons.[266] [267] [268] [269] [270] [271] [272]

1. Outline policy directions rapidly: It is important to develop *strategic* policy showing the broad directions of health sector development as early as possible to guide international input to health, and take advantage of both influxes of money and expertise and, potentially, an openness to change, even at the risk of narrow consultation with local actors.

2. Differentiate different policy 'streams': Slowing the pace of policy response strengthens its content but in most post–conflict settings, producing speedy guidance in some areas, while not desirable, is necessary and usually inescapable. Identifying and separating out matters that require immediate policy guidance from those that can be developed at a slower pace allows effort and human resources to be more effectively focussed.

3. Provide technical expertise in policy development: Individuals are crucial to shaping the policy process both because of their technical knowledge and the ability they have to relate to other actors. An experienced, credible and consistent team of policy developers, with expertise in change management and communication as well as health systems, organisational management and finance, is needed as early as possible.(13)

4. Focus on health systems: Creating policy that reinstates the elements on which a functioning health service depends is critical. Many of the urgent health issues prevalent in post-conflict situations cannot be tackled in the absence of, for example, a competent and balanced workforce, or a performing supply system. Programme-focussed policy does not provide the foundation on which a health system can grow.(14)

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(13) Specific suggestions from the literature above include developing the capacity for policy analysis and strategy development in the office of every humanitarian agency. Direct resources to strengthening the institutional and managerial capacity of government staff. Develop methods to better understand the policy process, for example political mapping or stakeholder analysis. Provide support to implementing agencies in areas such as developing work-plans, indicators, and monitoring and evaluation systems.

(14) Link the policy to initiatives in other sectors (for example, human resources development, finance, management, education etc. Develop new techniques to prioritise health expenditures. Design the health system to ensure geographic and social equity as conflict results in greater inequities and social divisions. Consolidate and support positive initiatives and resiliencies that have occurred within the health system during a conflict. Include systemic policy goals and organisational principles for the health care system, as well as a medium-term health strategy. Components could include: primary and secondary care, hospital services, public and environmental health, mental health and physical disability, reproductive health, national drug policy, health management, human resources development, cost recovery mechanisms, public-private mix, the role of NGOs, and essential infrastructure and support. Ensure sustainability for the MoH in terms of financial and human resources, and avoid underestimation of recurrent costs. It is crucial that funds are allocated for the payment, management, and training of the civil service to avoid problems of low morale and corruption/coping strategies.

5. Don't rebuild old system: analyse reality: Don't rebuild old systems, however 'glorious'; experience shows long-standing conflicts irretrievably change the environment for health services. Focused analysis of political, institutional, financial, cultural and human factors is essential to shaping policy debate and convincing co-ordination, as is investment of time and money in the tools (including solid, widely accessible information) and skills needed to do this.

6. Ownership and consultation: genuine commitment to policy directions by national players is essential to successful long term implementation. Involving implementers and communities helps to curb unrealistic expectations. Inevitably narrow consultation in initial phases of strategic guidance must be compensated for by the development of policy fora which facilitate broad ranging debate as soon as possible.[15]

7. Link co-ordination to resource allocation: Bodies intended to guide external partners/inputs must have some degree of authority over resource allocation and be linked into strategic policy development discussion if they are to have any impact. Even with this, co-ordination mechanisms should aim to inspire and convince since capacity to control in post-conflict settings is limited.

8. Manage information proactively: Skilled gathering, collation, analysis AND dissemination of information removes much confusion and potential for misunderstanding and mistrust in a fast moving, complex situation.

[15] Address issues of legitimacy, power and authority in order to allow for decision making and resource allocation. Ensure lead policy actors have a clear mandate from other stakeholders. Support policy implementation by national and local authorities.

ANNEX 2 – A RESEARCH AGENDA FOR COMPLEX POLITICAL EMERGENCIES

1. *Impact of conflict on health status/burden of disease*

- How do the causes and characteristics of conflict (cause, duration, intensity, stages of conflict) have differential effects on health and health systems?
- How does disease impact affected populations, and how does conflict change the patterns of disease and the disease agents?
- What are the baseline, and changing patterns of morbidity and mortality?

2. *Response of communities, care providers, health services and health systems to conflict*

- What is the degree of resilience and vulnerability of health systems and communities? How can we assess the status of communities and health systems confronted with crisis in order to predict to some extent how well they will cope? How and why does the degree of resilience/vulnerability differ between them? What successful coping mechanisms are adopted at the micro level that can be applied in other settings and translated in a macro perspective?
- What is the ability of existing health systems to continue to perform? How could we identify the point of irreversible decline, beyond which conservative interventions are ineffective? The short- and long term results of conservative vs. radical approaches, introduced to sustain flagging health systems, need to be studied and understood.
- How does the targeting of health systems / services /staff by warring parties affect their ability to address the health needs of the population? What lessons have been learned about protecting health systems, services, and staff from being targeted in such environments?
- How to identify broad secular trends, which the conflict can have magnified but not caused (such as brain drain, lack of production of health workers and privatisation), and which will persist even when the conflict is over?
- Comparative efficiency and equity of different approaches to the rationing of health care at local level, given limited, inadequate and shrinking resources.

3. *The rationale, characteristics and effects of internal and external interventions*

- Given limited resources, what is the best level of care? What are the tradeoffs between effectiveness, efficiency, equity and sustainability of health services provided in conflict situations and the tradeoffs between international standards of care and local habits and realities?
- How do the dynamics between stakeholders, both internal and external, influence health and the effectiveness of health policy and practice? Are these dynamics based on previous learning? How does the interplay between stakeholders evolve? What

strategies have been used to maintain MoH planning and policy-making capacities in war situations?

- What mechanisms should be adopted to promote uniformity of treatment guidelines and protocols (for example for malaria and other infectious diseases) among humanitarian agencies providing assistance and care in a conflict or post-conflict environment?
- What role does the military (occupying, peace keeping and rebel forces) play in the provision of effective health services? Is the risk of undermining humanitarian neutrality worth the benefits reaped by giving responsibilities in service provision to the military?
- What is the role of traditional medical practice in the health of communities in conflict or crisis situations? Does traditional health care get strengthened or weakened in times of crisis? What can be done to determine which elements of traditional practice may be health-promoting or protecting (e.g. those focused on mental health), while recognising that other elements may be dangerous to health (e.g. some traditional medicine used instead of antibiotics for STDs).

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